

<b>Case Number:</b>	CM15-0088793		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	07/27/2006
<b>Decision Date:</b>	07/03/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 67 year old male, who sustained an industrial injury on 7/27/06. The injured worker was diagnosed as having localized primary osteoarthritis, osteoarthritis, osteoarthritis of hip, osteoarthritis of knee, traumatic arthropathy of knee, knee joint ankyloses, hip pain, knee pain and lumbosacral spondylosis without myelopathy. Treatment to date has included physical therapy, oral medications including narcotics, right knee arthroscopy, total knee replacement and revision and right knee total knee replacement. Currently, the injured worker reports decreasing pain and increasing function on 4/15/15. Physical exam noted right knee postoperative swelling with decreased range of motion. A request for authorization was submitted for Amitriptyline, Tramadol and Diclofenac retrospectively for date of 10/12/11.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Retrospective Amitriptylin (10/21/11): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Page(s): 6. Decision based on Non-MTUS Citation ACOEM chapter 2 physical examination.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline Page(s): 13.

**Decision rationale:** The patient presents with an industrial injury. The current request is for retrospective Amitriptyline (10/12/11). The treating physician states, in an IMR application dated 04/22/15, "Amitriptyline." (1A) The MTUS guidelines state, "Recommended. Amitriptyline is a tricyclic antidepressant. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated." In this case, the treating physician, in the documents available for review, has failed to provide any medical necessity or dosing instructions for the above-indicated request. In the absence of any documentation containing subjective or objective findings, let alone dosing instructions, this reviewer is unable to determine the medical necessity of this request. As such, the current request is not medically necessary and the recommendation is for denial.

**Retrospective Tramadol (10/12/2011):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 6. Decision based on Non-MTUS Citation ACOEM chapter 2 physical examination.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** The patient presents with an industrial injury. The current request is for retrospective Tramadol (10/12/11). The treating physician states, in an IMR application dated 04/22/15, "Tramadol." (1A) The MTUS guidelines state, "Central acting analgesics: an emerging fourth class of opiate analgesic that may be used to treat chronic pain. This small class of synthetic opioids (e.g., Tramadol) exhibits opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Central analgesics drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain. (Kumar, 2003) Side effects are similar to traditional opioids." In this case, the treating physician, in the documents available for review, has failed to provide any necessity or dosing instructions for the above-indicated request. In the absence of any documentation containing subjective or objective findings, let alone dosing instructions, it is impossible to determine the medical necessity of this request. As such, the current request is not medically necessary and the recommendation is for denial.

**Retrospective Pencream (10/12/11):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 6. Decision based on Non-MTUS Citation ACOEM chapter 2 physical examination.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The patient presents with an industrial injury. The current request is for retrospective Pencream (10/12/11). The treating physician states, in an IMR application dated 04/22/15, "PENcream." (1A) The MTUS guidelines state, "Largely experimental in use with few

randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004)." In this case, the treating physician, in the documents available for review, has failed to provide any necessity or dosing instructions for the above-indicated request. In the absence of any documentation containing subjective or objective findings, let alone dosing instructions, it is impossible to determine the medical necessity of this request. As such, the current request is not medically necessary and the recommendation is for denial.

**Retrospective Diclofenac (10/12/ 2011): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 6. Decision based on Non-MTUS Citation ACOEM chapter 2 physical examination.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

**Decision rationale:** The patient presents with an industrial injury. The current request is for retrospective Diclofenac (10/12/11). The treating physician states, in an IMR application dated 04/22/15, "Diclofenac." (1A) The MTUS guidelines state, "Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors." In this case, the treating physician, in the documents available for review, has failed to provide any necessity or dosing instructions for the above-indicated request. In the absence of any documentation containing subjective or objective findings, let alone dosing instructions, it is impossible to determine the medical necessity of this request. As such, the current request is not medically necessary and the recommendation is for denial.