

<b>Case Number:</b>	CM14-0091716		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	01/31/2002
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	05/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 records presented for review indicate that this 56-year-old female was reportedly injured on January 31, 2002. The mechanism of injury is noted as a slip and fall. The most recent progress note, dated April 29, 2014, indicates that there were ongoing complaints of neck pain and low back pain. Pain is rated at 7/10 without medications and 5/10 with medications. The use of medications is stated to help the injured employee walk, exercise, and do activities around the house. The physical examination demonstrated tenderness along the cervical spine paraspinal muscles, trapezius, and rhomboids. There was also tenderness along the lumbar spine and the sciatic notch. Neurological examination indicated decreased sensation over the left lateral forearm and shoulder. Diagnostic imaging studies were not reviewed during this visit. Previous treatment includes steroid injections and chiropractic care. A request had been made for Amitriptyline, MS Contin, Neurontin, Prozac, and Motrin and was not certified in the pre-authorization process on May 30, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Amitriptyline HCL 25mg # 90 3 refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-15 of 127..

**Decision rationale:** According to the progress note dated April 29, 2014, the injured employee has radicular findings of the left upper extremity with decreased sensation on physical examination. Considering this, this request for Amitriptyline is medically necessary per MTUS guidelines.

**MS Contin CR 30mg # 90 3 refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-75, 78, 93 of 127.

**Decision rationale:** The California MTUS Guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain in the progress note, dated April 29, 2014, and documents objective decrease in pain and increased ability to function and perform activities of daily living with use of this medication. As such, this request for MS Contin is medically necessary.

**Neurontin 600mg # 120 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20, 49 of 127.

**Decision rationale:** According to the medical record, the injured employee is already taking an Amitriptyline for radicular symptoms in the upper extremities. This medication is stated to be beneficial in reducing the injured employee's upper extremity symptoms. Considering this, this request for Neurontin is not medically necessary per MTUS guidelines.

**Prozac 20mg #30 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants.

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

**Decision rationale:** According to the attached medical record the injured employee is already prescribed antidepressant amitriptyline for upper extremity symptoms. The use of Prozac would be redundant either for neuropathic symptoms or depression. As such, this request for Prozac is not medically necessary per MTUS guidelines.

**Motrin 600mg # 90 3 refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): Page 22 of 127..

**Decision rationale:** Ibuprofen is a nonselective, non-steroidal anti-inflammatory medication which has some indication for chronic low back pain. When noting the injured employees diagnosis and signs/symptoms, there is a clinical indication for the use of this medication as noted in the applicable guidelines. The request for Motrin 600 mg is considered medically necessary per MTUS guidelines.