

<b>Case Number:</b>	CM14-0210318		
<b>Date Assigned:</b>	12/23/2014	<b>Date of Injury:</b>	04/24/2002
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	12/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### **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. 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  
Certification(s)/Specialty: Physical Medicine & Rehabil

### **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 patient is a 55-year-old female with date of injury of 04/24/2002. According to progress report dated 12/01/2014, the patient presents with severe neck pain that is located in the left lateral part of the neck. There is radiation of pain to the left arm, ankles, feet, left shoulder, and neck. The patient has had a recent spinal cord stimulator trial, and the patient reports 35% reduction in pain. The patient reports pain with medication is 3/10, without medication is 10/10. The patient reports that with medications she is able to do simple chores around the house and minimal activities outside the house 2 times a week. Without medication, the patient stays in bed at least half the day and there is no contact with the outside world. CURES report was last addressed on 09/24/2014 and that last UDS is from 08/11/2014. The patient's current medication regimen includes Lexapro, Xanax, clonidine 0.1 mg, Pepcid 40 mg, fluocinonide topical cream, Flexeril, Latuda, bupropion HCl, aspirin, Excedrin ES, Senokot, sublingual, Lunesta, terazosin, Avinza extended release, Roxicodone, imipramine, and Norco. Examination of the lumbar spine revealed tenderness. Range of motion is restricted with moderate pain with motion. X-ray exam of the cervical spine dated 06/08/2009 revealed marked narrowing of the intervertebral disk space at C4-C5 and complete collapse of the disk space at C5-C6 and C6-C7. At both C6-C7 and C5-C6, there is anterior-posterior osteophyte formation. There is neuroforaminal narrowing on the right at C3-C4 and C5-C6. Neuroforaminal narrowing on the left is

present predominantly at C4-C5 and C6-C7. The listed diagnoses are: 1. Chronic pain syndrome. 2. RSD lower extremity. 3. Injury to peroneal nerve, chronic. 4. Chronic pain due to trauma. 5. COAT, chronic. 6. Pain in joint involving lower leg, chronic. The patient's work status is permanent and stationery. The utilization review denied the request on 12/11/2014. Treatment reports from 08/11/2014 through 12/01/2014 were provided for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Roxicodone 15mg #60: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medication for chronic pain; Criteria for use of Opioids Page(s): 60-61, 76-78, 88-89.

**Decision rationale:** This patient presents with chronic neck and low back pain. The current request is for Roxicodone 15 mg #60. For Chronic opiate use, the MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Review of the medical file indicates the patient has been utilizing this medication as early as 08/11/2014. According to treatment reports from 08/11/2014 through 12/01/2014, medications provide symptomatic reduction in pain from 10/10 to average 3/10. It is noted that relieving factors of patient's chronic pain include ice, narcotic analgesics, rest, and TENS unit. With current medication regimen, the patient is able to do simple chores around the house and participate in activity outside the house 2 times a week. Without medications, the patient stays in bed at least half the day with "no contact with the outside world." In this case, the treating physician has provided adequate discussions addressing the 4 A's as required by MTUS for opiate management. The patient has no reported adverse side effects, and urine drug screens have been consistent with the medications prescribed. Medication agreement is signed and on file which is dated 09/27/2013 and CURES was addressed on 09/24/2014. It appears the patient is able to function, and there is a significant decrease in pain with current medication regimen with no noticed side effects or aberrant behaviors. The requested Roxicodone is medically necessary.

#### **Imipramine 10mg #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia treatment

**Decision rationale:** This patient presents with chronic neck and low back pain. The current request is for Imipramine 10 mg #90. The treating physician has not provided a rationale regarding why this medication is prescribed. Review of the medical records indicates the patient has been utilizing this medication at bedtime as early as 08/11/2014. It appears this medication is prescribed for patient's insomnia as the instructions are for the patient to utilize at bedtime. Imipramine is a tricyclic antidepressant. The ACOEM and MTUS do not specifically discuss Imipramine. The MTUS page 13 states, "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur." For insomnia, Official Disability Guidelines under its Pain Chapter, states "Sedating antidepressants (e.g., Amitriptyline, Trazodone, Mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression." In this case, the treating physician has provided no discussion regarding insomnia or depression. The requested Imipramine is not medically necessary.