

Case Number:	CM15-0119092		
Date Assigned:	06/29/2015	Date of Injury:	11/09/2010
Decision Date:	07/28/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/19/2015

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

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 55 year old male, who sustained an industrial injury on 11/09/2010. He reported that he fell off of a 10 foot ladder landing on his right side. The injured worker was diagnosed as having moderate depressive disorder, shoulder joint pain, lumbar disc degeneration, and cervical intervertebral disc degeneration. Treatment and diagnostic studies to date has included functional restoration program and medication regimen. In a progress note dated 02/03/2015 the treating physician reports chronic pain to the neck, shoulder, and the right leg. The injured worker's current medication regimen included Hydrocodone/Acetaminophen, Cymbalta, Gabapentin, Nortriptyline, and Tizanidine. The treating physician noted that the injured worker has had benefit with his current medication regimen that allows the injured worker to have an increase in activities, no adverse effects, and no evidence of aberrant activities. However, the documentation did not indicate the injured worker's pain level as rated on a pain scale prior to use of his medication regimen and after use of his medication regimen to indicate the effects with the use of his medication regimen. The treating physician requested the medication Nortriptyline 10 mg one tablet at bedtime with a quantity 30 and 3 refills noting current use of this medication as noted above. The treating physician also requested a lumbar epidural steroid injection to the low back with a quantity of one, but the documentation provided did not indicate the specific reason for the requested treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Steroid Injection, Low Back, Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 45.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injections, page 46.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any specific neurological deficits or remarkable diagnostics to support the epidural injections. There is no report of acute new injury, flare-up, progressive neurological deficit, or red-flag conditions to support for pain procedure. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the epidural injection. Lumbar epidural injections may be an option for delaying surgical intervention; however, there is not surgery planned or identified pathological lesion noted. Criteria for the epidurals have not been met or established. The Lumbar Epidural Steroid Injection, Low Back, Qty 1 is not medically necessary or appropriate.

Nortriptyline 10 mg Qty 30 with 3 refills, 1 tab at bedtime: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-14.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for Chronic Pain, 13-16.

Decision rationale: Per Guidelines, 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. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment; however, submitted reports have not demonstrated the medical indication or functional improvement from treatment already rendered with chronic pain complaints. Report has noted the patient with ongoing symptoms complaints without demonstrated specific functional benefit derived from treatment rendered to support for continued use. The Nortriptyline 10 mg Qty 30 with 3 refills, 1 tab at bedtime is not medically necessary or appropriate.