

Case Number:	CM15-0176752		
Date Assigned:	09/17/2015	Date of Injury:	01/27/1986
Decision Date:	12/11/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	09/08/2015

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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 65 year old female, who sustained an industrial injury on January 27, 1986, incurring upper and low back injuries, knees and shoulder injuries. She was diagnosed with lumbar and cervical sprains, cervical disc disease, bilateral knee meniscus tear and bilateral rotator cuff tears and bilateral carpal tunnel syndrome. Treatment included physical therapy, chiropractic sessions, transcutaneous electrical stimulation unit, cervical collar and medications, muscle relaxants, proton pump inhibitor, anti-inflammatory drugs, topical analgesic patches, pain medications and activity restrictions. She reported up to 50% relief and functional improvement with this current regimen of medications. She performed her activities of daily living independently with the aid of medications. Currently, the injured worker complained of persistent chronic pain with decreased range of motion in the cervical and lumbar spine. She noted loss of muscle strength in the bilateral knees with limited range of motion. The treatment plan that was requested for authorization on September 4, 2015, included prescriptions for Citalopram 40 mg #30 with 1 refill, Ibuprofen 800 mg #600 with 1 refill, Amitriptyline 25 mg #60 with 1 refill, and Glucosamine-Chondroitin 500mg-400mg #90 with 1 refill. On August 13, 2015, a request for Citalopram 40 mg with 1 refill was modified for 0 refills, Amitriptyline 25 mg #60 with 1 refill was modified to 13 tablets with no refill, and Ibuprofen and Glucosamine-Chondroitin were non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Citalopram 40mg #30 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): SSRIs (selective serotonin reuptake inhibitors).

Decision rationale: According to the Official Disability Guidelines, SSRIs are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain. There was no indication in the documentation supplied for review as to why the patient would need three antidepressants simultaneously. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly. Citalopram 40mg #30 with 1 refill is not medically necessary.

Ibuprofen 800mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The medical record contains no documentation of functional improvement. Guidelines recommend NSAIDs as an option for short-term symptomatic relief. Ibuprofen 800mg #60 with 1 refill is not medically necessary.

Amitriptyline 25mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Tricyclics.

Decision rationale: According to the MTUS, tricyclics are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. 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. Indications for this medication were not documented in the PR-2 supplied for review. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly. Amitriptyline 25mg #60 with 1 refill is not medically necessary.

Glucosamine-Chondroitin 500mg-400mg #90 with 1 refill: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Glucosamine (and Chondroitin Sulfate).

Decision rationale: According to the MTUS, glucosamine is recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride (GH). There is documentation of knee osteoarthritis. I am reversing the previous utilization review decision. Glucosamine-Chondroitin 500mg-400mg #90 with 1 refill is medically necessary.