

<b>Case Number:</b>	CM15-0067346		
<b>Date Assigned:</b>	04/15/2015	<b>Date of Injury:</b>	03/20/1993
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/09/2015

### 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: Texas, Florida, 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 54 year old female, who sustained an industrial injury on 03/20/1993. She has reported subsequent neck pain and was diagnosed with cervical stenosis, cervical degenerative disc disease and neuropathic pain. Treatment to date has included oral pain medication. In a progress note dated 06/19/2014, the injured worker complained of mild neck and arm pain. Objective findings were notable for decreased range of motion of the neck and motor weakness in the left arm and finger extensors. A request for authorization of Ibuprofen, Zolof and Nortriptyline was made.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ibuprofen 800 mg #90 with 4 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), NSAIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: Pain interventions and treatments 8 C.C.R. 9792.20 - 9792.26 Page(s): 67 of 127.

**Decision rationale:** This claimant was injured 22 years ago; there was only mild neck and arm pain described, although there is decreased range of motion of the neck, and motor weakness in the left arm and finger extensors. The MTUS recommends NSAID medication for osteoarthritis and pain at the lowest dose, and the shortest period possible. The guides cite that there is no reason to recommend one drug in this class over another based on efficacy. Further, the MTUS cites there is no evidence of long-term effectiveness for pain or function. This claimant though has been on some form of a prescription non-steroidal anti-inflammatory medicine for some time, with no documented objective benefit or functional improvement. The MTUS guideline of the shortest possible period of use is clearly not met. Without evidence of objective, functional benefit, such as improved work ability, improved activities of daily living, or other medicine reduction, the MTUS does not support the use of this medicine. It is appropriately non-certified. The request is not medically necessary.

**Zoloft 50 mg #90 with 4 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Anxiety Medications.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, under Antidepressants.

**Decision rationale:** The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. This claimant was injured 22 years ago; there was only mild neck and arm pain described, although there is decreased range of motion of the neck, and motor weakness in the left arm and finger extensors. There is no mention of depression or significant chronic pain of a severe nature. Regarding antidepressants to treat a major depressive disorder, the ODG notes: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. In this case, it is not clear what objective benefit has been achieved out of the antidepressant usage, how the activities of daily living have improved, and what other benefits have been. It is not clear if this claimant has a major depressive disorder as defined in DSM-IV. If used for pain, it is not clear what objective, functional benefit has been achieved. The request is appropriately non-certified. The request is not medically necessary.

**Nortriptyline 75 mg #30 with 4 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, under Antidepressants.

**Decision rationale:** The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. This claimant was injured 22 years ago; there was only mild neck and arm pain described, although there is decreased range of motion of the neck, and motor weakness in the left arm and finger extensors. There is no mention of depression or significant chronic pain of a severe nature. Regarding antidepressants to treat a major depressive disorder, the ODG notes: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. In this case, it is not clear what objective benefit has been achieved out of the antidepressant usage, how the activities of daily living have improved, and what other benefits have been. It is not clear if this claimant has a major depressive disorder as defined in DSM-IV. If used for pain, it is not clear what objective, functional benefit has been achieved. The request is appropriately non-certified. The request is not medically necessary.