

<b>Case Number:</b>	CM13-0002475		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	11/14/2003
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	05/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2013

### 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 Occupational Medicine and is licensed to practice in California. 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 patient is a 55 year-old female with date of injury 11/14/2003. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 04/25/2013, in summary, lists subjective complaints as pain in the low back and right knee. Objective findings: Examination of the lumbar spine revealed moderate tenderness and spasms in the paravertebral musculature. Range of motion was decreased in flexion and extension. Examination of the right knee revealed tenderness in the medial and lateral compartment and decreased range of motion to the right. Objective findings: No record of a physical examination was supplied for review. Diagnosis: 1. Cervical myofascial strain/sprain 2. Thoracic myofascial strain/sprain 3. Dyspepsia 4. Fracture, right radial head 5. Depression 6. Left knee contusion 7. Fall, due to right knee giving out 8. Internal derangement, left shoulder 9. Internal derangement, left knee 10. History of DVT and pulmonary embolism 11. Fracture, left 2nd toe 12. Status post left knee replacement 13. Home/yard, due to left knee buckling 14. Contusion, facial. Patient has completed 12 sessions of physical therapy to date. The only medical record provided for review that has evidence of the patient being prescribed the following medications was the request for authorization dated 04/25/2013. Medications: Zoloft 100mg, #90. e right knee revealed tenderness in the medial and lateral compartment and decreased range of motion to the right. Objective findings: No record of a physical examination was supplied for review. Diagnosis: 1. Cervical myofascial strain/sprain 2. Thoracic myofascial strain/sprain 3. Dyspepsia 4. Fracture, right radial head 5. Depression 6. Left knee contusion 7. Fall, due to right knee giving out 8. Internal derangement, left shoulder 9. Internal derangement, left knee 10. History of DVT and pulmonary embolism 11. Fracture, left 2nd toe 12. Status post left knee replacement 13. Home/yard, due to left knee buckling 14. Contusion, facial. Patient has completed 12 sessions of physical therapy to date. The only medical record provided for review that has evidence of the

patient being prescribed the following medications was the request for authorization dated 04/25/2013. Medications: 1. Zoloft 100mg, #90. SIG: po qhs.

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

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

**CERVICAL MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

**Decision rationale:** MRI or CT is recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. None of the above documentation is associated with the request. The Cervical MRI is not medically necessary.

**ZOLOFT 100MG #90 WITH 3 REFILLS:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, SSRIS Page(s): 107.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), 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. There is no documentation in the body of the report associated with the request to substantiate the request for Zoloft, but she does carry a diagnosis of depression which is stated in that section. Based on this stated diagnoses, the number of tablets prescribed, and the number of refills requested, it is clear that the patient has been taking Zoloft previous to the current request. Zoloft 100mg #90 with 3 refills is medically necessary.