

Case Number:	CM13-0071495		
Date Assigned:	01/08/2014	Date of Injury:	04/24/2006
Decision Date:	06/11/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/27/2013

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 Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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 injured worker is a 34-year-old who reported an injury on April 24, 2006. The medication history included Norco 10/325 mg tablets 2 times a day, Dexilant DR 30 mg capsules 2 times a day, Lidoderm 5% patches 2 times a day, Lexapro 20 mg 2 tablets 2 times a day, Cymbalta 60 mg capsules, Lunesta 2 mg tablets, and Neurontin 800 mg tablets as of May of 2013. The mechanism of injury was not provided. The documentation of November 19, 2013 revealed the injured worker had complaints of severe left ankle pain. The injured worker indicated the reflex sympathetic dystrophy had progressed to her calf and to her knee. The injured worker indicated she was unable to fully bear weight on her leg. It was indicated the injured worker was more depressed especially without medications. The injured worker noted she was not taking her medications as prescribed and had been out of medications for 3 months. The injured worker indicated she had a severe escalation of pain and was less functional. The physical examination indicated the injured worker had an antalgic gait with decreased weightbearing on the left leg moving in a step to gait pattern. The injured worker had limited range of motion in the lumbar spine. On palpation, the injured worker had tenderness to palpation of the paravertebral muscles, trigger points, and trigger points with a twitch response along with radiating pain on palpation at L5 level. The injured worker indicated it referred to her buttocks with palpation on the right side. The spinous process tenderness was noted on L4 and L5. It was indicated the injured worker could not walk on heels or toes and had spasms with palpation diffusely. The injured worker had swelling at L5-S1. The inspection of the left ankle revealed swelling and the foot was dusky in color. Movements were restricted with decreased flexion, dorsiflexion, eversion, and inversion limited by pain. The injured worker had allodynia of the whole foot, ankle, and knee that was worse distally. The sensory examination revealed light sensation was decreased over the ulnar nerve distribution on the left. Diagnoses included sprain and strain of the ankle, lumbar or

lumbosacral disc degeneration, reflex sympathetic dystrophy not otherwise specified, closed ankle fracture not otherwise specified, ankle arthroscopy and sprains and strains of the ankle not otherwise specified. The treatment plan included Norco 10/325 mg 1 tablet 4 times a day with quantity 120 with 1 refill, and Lexapro 20 mg tablets. The documentation submitted in appeal dated December 19, 2013 revealed with the use of Norco, the injured worker was able to stay off Duragesic and was able to decrease her dose of Norco from 8 tablets a day to 3 or 4 tablets a day. It was indicated the injured worker needed fast acting medication that would provide alleviation of pain to permit some level of functionality with activities of daily living, and some minimal social life. Without pain control, the injured worker would be semi-sedentary. The injured worker had a urine drug screen and was noted to have a long term controlled substance agreement. It was indicated that a physician would take the opportunity to wean and prescribe lower doses.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION FOR LEXAPRO 20 MG BETWEEN 11/19/2013 AND 01/06/201:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Section, Page(s): 13.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend antidepressants as a first line medication for the treatment of neuropathic pain and they are recommended specifically if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication since May of 2013. There was a lack of documentation of an objective decrease in pain and objective functional improvement with the medication. The request as submitted failed to indicate the quantity and frequency for the requested medication. The request for one prescription of Lexapro 20 mg is not medically necessary or appropriate.

1 PRESCRIPTION FOR NORCO 10-325 MG #120 BETWEEN 11/19/2013 AND 01/06/201: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications For Chronic Pain; Ongoing Management Page(s): 60, 78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective increase and function,

objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication since May of 2013. There was lack of documentation of objective functional improvement and objective decrease in pain. It was documented the injured worker was being monitored through urine drug screens and a contract as per the subsequent documentation. There was a lack of documentation indicating the injured worker was being monitored for side effects. The request as submitted failed to indicate the frequency and quantity for the requested medication. The request for one prescription for Norco 10/325 mg, 120 count, is not medically necessary or appropriate.