MAXIMUS Federal Services

Case Number:	CM14-0122006		
Date Assigned:	08/06/2014	Date of Injury:	06/18/2003
Decision Date:	09/16/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/01/2014

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 53-year-old male who reported an injury on 06/18/2003, and reportedly sustained injuries to his neck and back when tripped over a double dolly. The injured worker was evaluated on 07/17/2014 and it was documented that the injured worker's condition remained the same. He reported an increased pain to his lower back and right knee. He reported being unable to walk due to knee and low back pain. He stated that he was sleeping 6 hours per night. He needed assistance with reaching and lifting activities. Pain was rated at 6/10. He was not attending any therapy due to pain in his knee and back. He reported doing cardiovascular 3 times per week for 40 minutes. The physical examination revealed there were trigger points noted to the lumbar paraspinals. The neurological and motor examinations were both abnormal. He had an altered gait and was using a cane for 10 days. The injured worker was diagnosed with lumbosacral neuritis. The medications included Lisinopril, Lexapro, Flexeril, lovastatin, and atenolol. The injured worker is currently taking Percocet 10/325 mg up to 4 times per day to allow him to function around the house and Lexapro 20 mg tablets daily for injury caused depression. The request for authorization or rationale was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review of Lexapro 20 mg #60 DOS 7/17/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain-Antidepressants for chronic pain Page(s): 13, 16, and 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Selective Serotonin and norepinephrine reuptake inhibitors (SNRIs) Page(s): 15.

Decision rationale: The requested is non-certified. California (MTUS) Chronic Pain Medical Guidelines recommends Lexapro as a selective serotonin and norepinephrine reuptake inhibitors (SNRIs) and FDA-approved for anxiety, depression, diabetic neuropathy, and Fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The documents submitted failed to indicate the injured worker's outcome measurements while taking Lexapro Furthermore, the documents submitted failed to indicate the outcome measurements of physical therapy, home exercise regimen, and pain medication management. In addition, the request lacked frequency, and duration. As such, the request for retrospective review Lexapro 20mg # 60 DOS 07/17/2014 is not medically necessary.

Retrospective review of Percocet 10-325 mg #60 DOS 7/17/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity of pain relief. The provider failed to submit urine drug screen indicating opioids compliance for the injured worker. There was no outcome measurements of conservative measures indicated for the injured worker such as physical therapy or home exercise regimen for the injured worker. There was lack of documentation of long-term functional improvement for the injured worker. In addition, the request lacked frequency, and duration. Given the above, the request for retrospective review of Percocet 10/325 mg #60 DOS 07/17/2014 is not medically necessary.