

Case Number:	CM14-0023641		
Date Assigned:	06/11/2014	Date of Injury:	08/04/2000
Decision Date:	07/16/2014	UR Denial Date:	01/26/2014
Priority:	Standard	Application Received:	02/25/2014

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 Occupational Medicine and is licensed to practice in Texas. 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 64 year old female injured on 08/04/00 due to an undisclosed mechanism of injury. Current diagnoses include right shoulder rotator cuff syndrome and status post bilateral knee arthroscopies with early degenerative changes. Clinical note dated 04/22/14 indicates the injured worker is 3 months status post right knee surgery and 5 months status post left knee surgery. It is noted that the injured worker underwent partial meniscectomies with noted osteoarthritis in bilateral knees. Physical examination of the right shoulder revealed decreased range of motion, strength 5/5 of the rotator cuff, positive impingement sign, negative external rotation lag test, and normal sensation. Examination of the bilateral knees revealed tenderness along the patellar tendon on the right, full range of motion, mild joint line tenderness primarily medially bilaterally, and stable with negative Lachman's test. Treatment plan includes request for Orthovisc and subacromial injection to the right shoulder. The injured worker is also advised to continue with a home exercise program which included pool therapy. The initial request for meds x 5, Norco and Lexapro was initially non-certified on 01/26/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDS X 5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back Complaints, page(s) Initial Care.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, comfort is often a patient's first concern. Nonprescription analgesics will provide sufficient pain relief for most patients with acute and subacute symptoms. If treatment response is inadequate (i.e., if symptoms and activity limitations continue), prescribed pharmaceuticals or physical methods can be added. Comorbid conditions, side effects, cost, and provider and patient preferences guide the clinician's choice of recommendations. However, the request for meds x 5 does not specify the treatment to be provided limiting the ability to substantiate the medical necessity of the request. As such, the request for meds x 5 cannot be recommended as medically necessary.

NORCO 10 MG-325: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Norco 10 MG-325 cannot be established at this time.

LEXAPRO 10 MG: 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): Mental Illness & Stress, Escitalopram (Lexapro®).

Decision rationale: As noted in the Official Disability Guidelines, Lexapro is recommended as a first-line treatment option for major depressive disorder. However, there is no indication in the documentation that the patient has symptoms associated with or a diagnosis consistent with depression. As such, the request for Lexapro 10mg cannot be recommended as medically necessary.