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| Case Number: | CM14-0026683 | | |
| Date Assigned: | 06/13/2014 | Date of Injury: | 01/10/1997 |
| Decision Date: | 07/18/2014 | UR Denial Date: | 02/18/2014 |
| Priority: | Standard | Application Received: | 03/03/2014 |

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 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 55year old male with reported injury on 01/10/1997. The mechanism of injury was not provided. The injured worker had an exam on 12/18/2013 with complaints of severe pain which caused him to slip and fall at home re-injuring his back and right knee. The injured worker also complained of left testicle pain that increased with any standing, sitting, bending, lifting and climbing activity. His back pain was sharp and stabbing. He continued to have hearing loss, depression, anxiety and stress due to prolonged medication use. The injured worker had used hot and cold unit which limited his pain medication. His diagnoses were status post lumbar spine surgery X3, cervical spine intervertebral disc herniation with radiculopathy, hearing loss, decaying teeth and pain due to prolonged medication use, status post penile implant, severe depression, suicidal ideations, anxiety and stress, sleep deprivations and apnea, bilateral carpal tunnel release, severe hypertension and chest pain, stomach pain and abdominal pain. There was no documentation on a psychological evaluation provided. The request for authorization was signed and dated on 01/29/2014. The rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEXAPRO 20MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15.

Decision rationale: The request for Lexapro 20mg is non-certified. The injured worker has a history of depression, anxiety and stress, although there was a lack of documentation of a psychological evaluation. The California MTUS guidelines state that assessment of treatment efficacy of antidepressants should include not only pain outcomes, but also evaluation of function, changes in use of other analgesics medication, sleep quality and duration, and psychological assessment. There was no documentation on pain assessment and effectiveness nor on the quality of sleep and duration. The guidelines state that antidepressants have shown no specific effectiveness in the treatment of low back pain and radiculopathy. The request does not include the frequency or quantity of the proposed medication. There is not enough evidence to support the request for Lexapro, therefore the request is not medically necessary.