

Case Number:	CM15-0111728		
Date Assigned:	06/18/2015	Date of Injury:	10/13/1994
Decision Date:	07/16/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	06/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Emergency Medicine

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 65-year-old female, with a reported date of injury of 10/13/1994. The diagnoses include post lumbar laminectomy syndrome. Treatments to date have included oral medications and spinal cord stimulator. The medical report dated 03/11/2015 indicates that the injured worker had low back pain. It was noted that her pain level had remained unchanged since the last visit. She rated her pain 2 out of 10 with medications, and 4 out of 10 without medications. Her quality of sleep was fair, and since the last visit, her quality of life had remained the same. It was also noted that her activity level had remained the same. The objective findings include restricted lumbar range of motion, hypertonicity, spasm, tight muscle band on palpation of the paravertebral muscles, limited motor testing due to pain, grossly normal higher functions, and normal sensory examination. The treating physician requested Prozac 20mg #270. The rationale for the request was not indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prozac 20mg #270: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic pain Page(s): 13-16.

Decision rationale: Prozac is fluoxetine, an SSRI (selective serotonin reuptake inhibitor) antidepressant. As per MTUS Chronic pain guideline, antidepressants for chronic and neuropathic pain may be considered. Tricyclic antidepressants are considered 1st line and SNRIs are considered 2nd line, SSRIs are considered 3rd line and has poor evidence to show efficacy in chronic pain or neuropathic pain although it may have some benefit in patients with sleep or depressive symptoms. It has been shown to have poor efficacy in low back pain. MTUS guideline requires documentation of treatment efficacy which includes evaluation of function, changes in analgesic use, sleep and psychological assessment. The provider has failed to document anything to support use of Prozac. Pt continues to have baseline pain and has poor sleep. There is no appropriate documentation as to why a 3rd line medication is being used and there is no appropriate documentation of efficacy. The number of tablets requested is also not appropriate. The number of tablets requested would give the patient 9 months of medications. Prozac is not medically necessary.