

Case Number:	CM15-0023902		
Date Assigned:	02/13/2015	Date of Injury:	09/23/2009
Decision Date:	04/14/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/06/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 48-year-old male who reported an injury on 09/23/2009. The mechanism of injury was not provided. The documentation of 01/20/2015 revealed the injured worker did not feel better in terms of his ears and nose. The injured worker indicated he could hear better after the right tube placement on 11/24/2014. The injured worker walking 20 minutes a day, but it was noted to hurt his back a lot. The injured worker described the pain in mid back as constant, dull, and achy and averaged a 7/10 to 8/10. The injured worker responded initially well to the radiofrequency ablation, but the last procedure was not successful. The injured worker underwent x-rays and an MRI of the thoracic spine. The injured worker had right arm pain that remained the same and the right arm started clicking and popping. The injured worker underwent and EMG/NCS of the right upper extremity, which revealed mild carpal tunnel syndrome, and isolated acute denervation of the right flexor carpi ulnaris muscle likely due to prior surgical procedures. The objective findings revealed tenderness to palpation at the cervical paraspinal muscles. Motor strength was 5/5 throughout the bilateral upper extremities with the exception of right elbow flexion and extension strength of 4+/5. The injured worker had tenderness to palpation at T5-8. The diagnoses included chronic pain syndrome, multiple fractures of thoracic spine, elbow fracture status post open reduction internal fixation surgery, neck sprain, rotator cuff shoulder syndrome and allied disorders, cubital tunnel syndrome, depressive disorder, sinusitis and sleep apnea. The treatment plan included Lexapro 20 mg by mouth every day #30. The injured worker had utilized the medications since at least 01/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lexapro 20mg #30 with 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend antidepressants as a first line medication for the treatment of neuropathic pain and they are recommended especially if pain is accompanied by insomnia, anxiety or depression. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of an objective decrease in pain and functional improvement. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. Given the above, the request for Lexapro 20 mg #30 with 3 refills is not medically necessary.