

<b>Case Number:</b>	CM13-0007857		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	10/13/2010
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	07/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2013

### 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 Family Medicine, and is licensed to practice in North Carolina. 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 patient is a 41-year-old with a reported date of injury of October 13, 2010. The patient has the diagnoses of complex regional pain syndrome of the wrist. Past treatment modalities have included surgery, stellate ganglion injection, medication, physical therapy, bracing, and acupuncture. The most recent provided progress reports by the primary treating physician dated July 30, 2013 indicates the patient has complaints of left wrist and left hand pain radiating to the forearm with episodic left wrist swelling and color change. Physical exam showed tenderness to palpation of the left wrist, hand and forearm. There was skin discoloration described as a purplish hue. There was decreased range of motion secondary to pain. Hyperalgesia, allodynia and hypoesthesia were positive. The treatment plan consisted of atrial of percutaneous spinal cord stimulator and continued medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lexapro 10mg, thirty count with one refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs Page(s): 107.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 14-16.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines addresses the use of antidepressants for chronic pain as follows: Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. (Finnerup, 2005) (Saarto-Cochrane, 2005) It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. (Namaka, 2004) More information is needed regarding the role of SSRIs and pain assessment. Lexapro is a selective serotonin reuptake inhibitor. The request for Lexapro 10mg, thirty count with one refill, is not medically necessary or appropriate.

**Biofreeze gel, quantity of one with two refills:** 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) low back.

**Decision rationale:** The California MTUS, the ACOEM and the ODG sections on the wrist do not specifically address Biofreeze gel in the setting of treatment for this patient's specific diagnosis and pain. The ODG section on low back does mention Biofreeze. Biofreeze is a non-prescription topical cooling agent with an active ingredient of menthol. It is meant to take the place of ice packs and is an optional form of cryotherapy for acute pain. This patient is not experiencing acute pain and the progress notes indicate that past treatment modalities have included heat/ice. The request for Biofreeze gel, quantity of one with two refills, is not medically necessary or appropriate.