

Case Number:	CM13-0038958		
Date Assigned:	12/18/2013	Date of Injury:	02/25/2012
Decision Date:	04/01/2014	UR Denial Date:	09/17/2013
Priority:	Standard	Application Received:	10/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Emergency Medicine and is licensed to practice in Florida. 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 physician 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:

This patient is a 50 year-old with a date of injury of 02/25/12. The mechanism of injury was described as cumulative trauma. A progress report included by [REDACTED], dated 08/02/13, identified subjective complaints of left and right wrist, forearm and elbow pain radiating to the shoulders. Also numbness in the left hand. Objective findings included tenderness to palpation of the cervical paravertebrals, shoulders, elbows and wrists. There was limited range-of-motion of the shoulder. There were also signs of a carpal tunnel syndrome. Diagnostic studies are not listed. Diagnoses indicate that the patient has "Bilateral shoulder impingement; Shoulder adhesive capsulitis; Repetitive trauma to the upper extremities; Bilateral carpal tunnel; Cervical strain". Treatment has included NSAIDs for over one year and a home exercise program. A Utilization Review determination was rendered on 09/17/13 recommending non-certification of "Voltaren 75 mg".

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 75mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Section Page(s): 67-73.

Decision rationale: Voltaren (diclofenac) is a non-selective NSAID (inhibits COX-1 and COX-2 enzymes). The Medical Treatment Utilization Schedule (MTUS) states that for osteoarthritis, NSAIDs are recommended "... at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors." For acute exacerbations of chronic back pain, the Guidelines recommend NSAIDs as second-line treatment after acetaminophen. For acute low back pain, studies have shown effectiveness no greater than placebo, and no more effective than acetaminophen. For chronic low back pain, NSAIDs are recommended for short-term symptomatic relief. A Cochrane review of the literature has suggested that NSAIDs are no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The Guidelines state: "There is no evidence to recommend one drug class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs (Celebrex) in terms of pain relief." The Guidelines further note that for patients with no gastrointestinal (GI) risk factors (age greater than 65; history of peptic ulcer or bleeding; concurrent use of aspirin, steroids, or anticoagulants; high dose/multiple NSAIDs) and no cardiovascular disease, non-selective NSAIDs are okay (e.g. ibuprofen, naproxen, etc.). If patients have intermediate GI risk factors, then a non-selective NSAID with a proton pump inhibitor (PPI) is recommended, and with high GI risk factors, a COX-2 selective agent plus a PPI is necessary. In this case, based upon the patient's complaints, the NSAID is for treatment of upper extremity pain. It appears that the claimant has been on the drug for over a year. None of the guidelines mentioned above support the chronic use of an NSAID over acetaminophen. There is no documentation in the record for the use of this second-line agent on a chronic basis. Therefore, there is no medical necessity for Voltaren.

Escitalopram 20mg: 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 Section Page(s): 13-16.

Decision rationale: Lexapro (escitalopram) is an SSRI class antidepressant. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines note that some antidepressants are: "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain (Feurstein, 1977) (Perrot, 2006)." The tricyclic agents are generally considered first-line unless they are ineffective, poorly tolerated or ineffective. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesics, sleep quality and duration as well as a psychological assessment. The optimal duration of therapy is not known. The Guidelines recommend that assessment of treatment efficacy begin at one week with a recommended trial of at least 4 weeks. It is recommended that if pain is in remission for 3-6 months, a gradual tapering of the antidepressants occur. The long-term effectiveness of antidepressants has not been established. For neuropathic pain, tricyclics agents are recommended as first-line. Recent

reviews also list tricyclics and SSNRIs (duloxetine and venlafaxine) as first-line options. Antidepressants are listed as an option in depressed patients with non-neuropathic pain, but effectiveness is limited. The Guidelines note that non-neuropathic pain is generally treated with analgesics and anti-inflammatories. Multiple controlled trials have found limited effectiveness with antidepressants in fibromyalgia, with the exception of duloxetine. The Guidelines state that in low back pain: "... tricyclic antidepressants have demonstrated a small to moderate effect on chronic low back pain (short-term pain relief), but the effect on function is unclear. SSRIs have not shown to be effective for low back pain (there was not a significant difference between SSRIs and placebo) and SNRIs have not been evaluated for this condition (Chou, 2007)." They further state that "SSRIs do not appear to be beneficial." No studies have specifically studied the use of antidepressants to treat pain from osteoarthritis. The Guidelines do note that in depressed patients with osteoarthritis, improving depression symptoms was found to decrease pain and improve functional status. The Guidelines state that tricyclic antidepressants specifically "... are recommended over selective serotonin reuptake inhibitors (SSRIs), unless adverse reactions are a problem." SNRIs are recommended as a first-line option for diabetic neuropathy. They note that there is no high quality evidence to support the use of duloxetine (SNRI) for lumbar radiculopathy. Related to SSRIs, the Guidelines state: "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 (Namarka, 2004). More information is needed regarding the role of SSRIs and pain." Based on the lack of support for the efficacy of the SSRI class of antidepressants as well as the recommendation of tricyclics as first-line when antidepressants are indicated, there is no medical necessity for Lexapro in this case.