

Case Number:	CM14-0177422		
Date Assigned:	10/30/2014	Date of Injury:	03/31/2011
Decision Date:	12/08/2014	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	10/27/2014

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 Occupational Medicine, and is licensed to practice in California. 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:

Patient is a 40 year-old female with date of injury 03/31/2011. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 09/04/2014, lists subjective complaints as pain in the bilateral upper extremities and neck; the greatest pain being the bilateral wrists. Objective findings: Examination of the cervical spine revealed tenderness to palpation at the cervical paraspinal muscles with muscle tension extending in the bilateral upper trapezius muscles. Range of motion was decreased by 20% with flexion. Sensations were decreased to light touch along the right upper extremity compared to the left. Motor strength was 5/5 for bilateral upper extremities. Tinel's was negative at the bilateral wrists. Diagnosis: 1. Carpal tunnel syndrome, bilateral 2. Epicondylitis, lateral, bilateral 3. Neck pain 4. Syndrome, cervicobrachial. The medical records supplied for review document that the patient has been taking the following medications for at least as far back as three months. Medications: Lexapro 5mg, 330 SIG: 1 tab QD and Ketamine 5% Cream, 60gms SIG: apply to affected area TID.

IMR ISSUES, DECISIONS AND RATIONALES

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

Escitalopram-Lexapro 5mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), SSRIs (selective serotonin reuptake inhibitors)

Decision rationale: According to the Official Disability Guidelines SSRIs are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. In the medical record provided for review, documentation of depression is lacking. In addition, the previous utilization review physician provided the patient with a weaning dose of Lexapro. Escitalopram-Lexapro 5mg #30 is not medically necessary.

Ketamine 5% Cream 60gm: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56.

Decision rationale: The MTUS states that Ketamine is not recommended and that there is insufficient evidence to support the use of Ketamine for the treatment of chronic pain. There are no quality studies that support the use of Ketamine for chronic pain. Ketamine 5% Cream 60gm is not medically necessary.

Functional Restoration Program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Chronic pain programs (functional restoration programs)

Decision rationale: Criteria for admission to a multidisciplinary pain management program delineated in the Official Disability Guidelines are numerous and specific. The medical record must document, at a minimum, which previous methods of treating the patient's chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, and an adequate and thorough multidisciplinary evaluation has been made. There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. The medical record does not contain documentation of the above criteria. Functional Restoration Program is not medically necessary.