MAXIMUS Federal Services

Case Number:	CM15-0202980		
Date Assigned:	10/19/2015	Date of Injury:	02/25/2014
Decision Date:	12/02/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	10/15/2015

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: Iowa, Illinois, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 23 year old male who sustained an industrial injury on 2-25-2014. A review of medical records indicates the injured worker is being treated for reflex sympathetic dystrophy of the upper limb and chronic pain syndrome. Medical records dated 9-2-2015 noted he is seen by psych and behavioral therapy for depression. He reports using medications appropriately with no aberrant drug related behaviors. Physical examination noted allodynia dorsum index and middle finger. Treatment has included Dilaudid and Ibuprofen. Utilization review form noncertified 60 tablets of Escitalopram 10mg and 4 patches of Butrans 5mcg-hr.

IMR ISSUES, DECISIONS AND RATIONALES

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

Escitalopram 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain, Buprenorphine. Decision based on Non- MTUS Citation Official Disability Guidelines (ODG), Treatment for Workers Compensation; Mental Illness & Stress Chapter, Online Edition, 2015; Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.uptodate.com/; escitalopram monograph; Selective serotonin reuptake inhibitors: Pharmacology, administration, and side effects.

Decision rationale: Up to date Dosing: Adult US labeling: Major depressive disorder, generalized anxiety disorder: Oral: Initial: 10 mg once daily; dose may be increased to a maximum of 20 mg once daily after at least 1 week. Canadian labeling: Note: Orodispersible tablets should only be used for doses that can be accommodated with whole tablets (ie, 10 mg or multiples of that). Major depressive disorder, generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD): Oral: Initial: 10 mg once daily (may consider 5 mg once daily where sensitivity is a concern); dose may be increased as tolerated to a maximum of 20 mg once daily. In poor CYP2C19 metabolizers, initiate at a dose of 5 mg once daily; may increase dose to a maximum of 10 mg once daily. Patients with GAD or OCD who require extended therapy should be maintained at the lowest effective dose and assessed periodically to determine the need for continued therapy. Hot flashes (off-label use): Oral: Initial: 10 mg once daily, increase to 20 mg once daily after 4 weeks if symptoms not adequately controlled. (Carpenter 2012; Freeman 2011) Panic disorder (off-label use): Initial: 5 mg once daily for 7 days, then increase dose to 10 mg once daily. Consider further dosage adjustments based on response and tolerability up to 20 mg once daily; mean dose in clinical trials was ~10 mg once daily. (Stahl 2003) Up to date SSRI Summary and Recommendations: Selective serotonin reuptake inhibitors (SSRIs) are frequently used as first-line antidepressants because of their efficacy, tolerability, and general safety in overdose. The six commonly available SSRIs are citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, and sertraline. (See 'Introduction' above.) SSRIs inhibit the serotonin reuptake pump and increase postsynaptic serotonin receptor occupancy. This initial action may cause subsequent changes involved in treating depression. SSRIs are selective in that they have relatively little affinity for other types of receptors. (See 'Pharmacodynamics' above.) The SSRIs may inhibit hepatic cytochrome P450 enzymes that metabolize other medications and cause drug-drug interactions. Citalopram and escitalopram inhibit liver enzymes less than other SSRIs and are thus the SSRIs of choice for situations in which drug-drug interactions are a concern. (See 'Drug-drug interactions' above.) There is no compelling evidence that one SSRI is more efficacious than another. Although a few analyses have found that escitalopram may possibly be more efficacious than citalopram, and sertraline may possibly be more efficacious than fluoxetine, there are questions about the clinical significance of the statistically significant differences that were observed. The choice of a particular SSRI is based upon cost, individual patient tolerance, and clinician experience, because efficacy appears to be comparable.- SSRIs should generally be started at their minimal effective dose: citalopram 20 mg, escitalopram 10 mg, fluoxetine 20 mg, fluvoxamine 50 mg, paroxetine 20 mg, andsertraline 50 mg. A process of trial and error is used to find the effective dose. Dose adjustments are made according to patient response, tolerability, and clinical urgency. Clinicians should not prescribe citalopram at doses that exceed 40 mg per day because of dose-dependent QT interval prolongation. In addition, the dose should not exceed 20 mg per day in patients with risk factors for increased serum concentrations of citalopram, including hepatic impairment, age >60 years, CYP2C19 variants that slowly metabolize citalopram, and concomitant medications that inhibit CYP2C19. (See 'Dose' above and 'Cardiac' above.) Common SSRI side effects include sexual dysfunction, drowsiness, weight gain, insomnia, anxiety, dizziness, headache, and dry mouth. In addition, observational studies suggest SSRIs may increase the risk of diabetes, abnormal bleeding, and

bone loss. (See 'Side effects' above.) While the patient is diagnosed with PTSD and depression, the treating physican did not detail how long the patient had been on the medication and if the medication was helping the patient. As such, the request for Escitalopram 10mg #60 is not medically necessary at this time.

Butrans 5mcg/hr #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Buprenorphine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Butrans.

Decision rationale: MTUS states that Suboxone, which is a brand name of the drug known as buprenorphine, is "recommended for treatment of opiate addiction. Also recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction." ODG states "Buprenorphine transdermal system (Butrans; no generics): FDA approved for moderate to severe chronic pain. Available as transdermal patches at 5mcg/hr, 10mcg/hr and 20mcg/hr. See also Buprenorphine for treatment of opioid dependence." The ODG states that Suboxone is "recommended as an option for treatment of chronic pain (consensus based) in selected patients (not first-line for all patients). Suggested populations: (1) Patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neuropathic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been detoxified from other high-dose opioids. Use for pain with formulations other than Butrans is off-label. Due to complexity of induction and treatment the drug should be reserved for use by clinicians with experience." The employee is using this medication for chronic pain. However, there is no medical documentation of any of the five conditions listed above which are the specific indications for using Suboxone instead of one of the first line agents. As such, the request for Butrans 5mcg/hr #4 is not medically necessary.