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| <b>Case Number:</b>   | CM15-0122989 |                              |            |
| <b>Date Assigned:</b> | 07/07/2015   | <b>Date of Injury:</b>       | 10/06/2009 |
| <b>Decision Date:</b> | 08/06/2015   | <b>UR Denial Date:</b>       | 06/02/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/25/2015 |

### 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

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 64 year old female, who sustained an industrial injury on 10/6/09. The initial diagnosis and symptoms experienced by the injured worker were not included. Treatment to date has included physical therapy, massage therapy, chiropractic care, acupuncture, home exercise program, medication, urine drug screen, steroid injection and radiofrequency ablation. Currently, the injured worker complains of neck, low back and hip pain rated at 7-8/10 and described as aching and an occasional sharp, shooting pain. The injured worker is diagnosed with lumbosacral spondylosis without myelopathy, lumbago, cervicgia, hip joint painful on movement. Her current work status was not included in the documentation. A note dated 5/20/15 states the injured worker has engaged in physical therapy, massage therapy, chiropractic care and acupuncture. The injured worker experienced partial, brief and/or temporary relief from the stated treatment regimens and home exercise helps minimally. The injured worker reports she does not gain relief from anti-inflammatory medication. A reduction of 70-80% in opioid pain medication use is planned. There are no deficits noted on exam neurologically or in muscle strength. There is a decreased range of motion due to pain and tenderness to palpation of the right hip. A note dated 12/23/14 states improvement in pain by 70% after the ablation and one dated 1/21/15 states a 10-20% reduction in pain after the steroid injection. The following medications, Citalopram 10 mg #30 with 4 refills and Soma 350 mg #30 with refill for one year are being requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Citalopram 10mg #30 with 4 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

**Decision rationale:** Regarding the request for citalopram, CA MTUS guidelines state that tricyclic and SNRI antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. 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. Within the documentation available for review, the medication is not a tricyclic or SNRI antidepressant for which use for pain would be indicated. Furthermore, there is no current documentation of symptoms/findings suggestive of depression, evidence of efficacy from prior use of the medication, or another clear rationale for its use. In the absence of clarity regarding those issues, the currently requested citalopram is not medically necessary.

**Soma 350mg #30 with refill x 1 year:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 of 127.

**Decision rationale:** Regarding the request for Soma, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Soma is not medically necessary.