

Case Number:	CM15-0091698		
Date Assigned:	05/18/2015	Date of Injury:	04/21/2005
Decision Date:	06/19/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	05/12/2015

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

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 was a 56 year old female, who sustained an industrial injury, April 21, 2005. The injured worker previously received the following treatments physical therapy, right wrist brace, Norco, Lexapro, Meloxicam, Tramadol, and Gabapentin was not tolerated, unable to take Cymbalta due to rapid heart rate, 3 level cervical fusion and home exercise program. The injured worker was diagnosed with reflex sympathetic dystrophy of the upper extremity, Lateral epicondylitis, chronic insomnia and shoulder-hand syndrome. According to progress note of April 21, 2015, the injured workers chief complaint was right shoulder, right arm, right forearm, right elbow, right wrist and right hand pain. The pain was described as burning and shooting. The pain interfered with sleeping. There was joint stiffness of the right shoulder, elbow and wrist joints. There was extreme weakness of the right upper extremity. The injured worker needed assistance with activities of daily living and driving. The physical exam noted right upper extremity pain. The injured worker continues to have severe pain and new symptoms of left elbow pain do to over use. The injured worker was using Norco for insomnia and pain. The injured responded well to Trazadone for insomnia, however was denied in the past. The treatment plan included prescriptions for Lexapro, Norco and Trazadone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lexapro 10 mg #30 with 5 refills: Upheld

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

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

Decision rationale: Lexapro (escitalopram oxalate) is an orally administered selective serotonin reuptake inhibitor (SSRI). Lexapro (escitalopram) is indicated for the acute and maintenance treatment of major depressive and generalized anxiety disorders. Per MTUS Chronic Treatment Pain Guidelines, selective serotonin reuptake inhibitors (SSRIs) such as Lexapro (a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline), are controversial based on controlled trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain; however, more information is needed regarding the role of SSRIs and pain. No high quality evidence is reported to support the use of Lexapro for chronic pain and more studies are needed to determine its efficacy. Submitted reports do not document or describe continued indication or specific functional improvement from Lexapro treatment. Although, the patient was noted to be intolerant of Cymbalta, there is also no mention of previous failed trial of TCA or other first-line medications without specific improvement in clinical findings from treatment rendered. The Lexapro 10 mg #30 with 5 refills is not medically necessary and appropriate.

Norco 10/325 mg #105: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent

severe pain for this chronic injury without acute flare, new injury, or progressive deterioration. The Norco 10/325 mg #105 is not medically necessary and appropriate.

Trazodone 50 mg #80: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for Chronic Pain, Anti-depressants for Treatment of Chronic Persistent Pain; Insomnia Treatment Page(s): 13-16, 535-536.

Decision rationale: Trazodone hydrochloride (Desyrel) is an antidepressant chemically unrelated to tricyclic, tetracyclic, or other known antidepressant agents and is indicated for the treatment of major depression. MTUS Medical Treatment Guidelines specifically do not recommend for Trazodone. Tolerance may develop and rebound insomnia has been found even after discontinuation, but may be an option in patients with coexisting depression that is not the case here. Submitted reports have not demonstrated functional benefit derived from the previous treatment rendered for this chronic injury. The Trazodone 50 mg #80 is not medically necessary and appropriate.