

<b>Case Number:</b>	CM15-0093453		
<b>Date Assigned:</b>	05/19/2015	<b>Date of Injury:</b>	10/26/2004
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2015

### 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: Pennsylvania, Ohio, 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 is a 54-year-old female, who sustained an industrial injury on 10/26/04. The injured worker was diagnosed as having depression, posttraumatic stress disorder, anxiety and opioid use disorder. Treatment to date has included cervical laminectomy, radiofrequency ablation of cervical facet joints, oral medications including Escitalopram, Depakote, Terbinafine, Albuterol, Clonazepam, Suboxone and Provigil. Currently, the injured worker complains of continued neck pain, which she describes as deep, dull and aching with episodic upper extremity radicular symptoms rated 3-6/10 dependent on activity. Physical exam noted hypertonia in posterior cervical region, supraspinatus, infraspinatus, trapezius latissimus dorsi and rhomboid major and minor; mild right sub occipital tenderness is noted and range of motion is restricted. A request for authorization was submitted for prescription for Escitalopram.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One prescription of Escitalopram 20mg #1000: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SSRI Anti-depressants Page(s): 107.

**Decision rationale:** MTUS recommends SSRIs when treating secondary depression related to chronic pain but not solely as a treatment for chronic pain. The records in this case discuss symptoms of depression vs. PTSD for which an SSRI anti-depressant has been prescribed. However, treatment guidelines and FDA labeling information recommend physician monitoring of this medication for effectiveness and side effects; for this reason a prescription for 1,000 tablets is not supported by the guidelines and indeed is so large as to likely reflect a clerical error of some type. Thus, this request is not medically necessary.