

Case Number:	CM13-0052365		
Date Assigned:	12/27/2013	Date of Injury:	04/20/2006
Decision Date:	08/12/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/15/2013

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 Orthopedic Surgery 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:

The injured worker is a 56 year-old female who was reportedly injured on April 20, 2006. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated December 5, 2013, indicates that there are ongoing complaints of sleep issues, insomnia, and depression. The physical examination demonstrated some memory loss and judgment issues. The December 4, 2013 note indicates ongoing pain in both upper extremities. The physical examination noted a normotensive individual with a slight decrease of shoulder range of motion. No motor or sensory loss in either upper extremities appreciated. Diagnostic imaging studies were not reviewed. Previous treatment includes multiple medications, psychiatric care, surgical intervention for the bilateral carpal tunnel and cubital tunnel syndrome and other conservative measures. A request was made for multiple medications and was not approved in the pre-authorization process on October 25, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

A RETROSPECTIVE REQUEST FOR EFFEXOR XR 75 MG #60 WITH ONE (1) REFILL WITH A DATE OF SERVICE OF 10/18/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-15.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 122.

Decision rationale: The requested is for a retrospective refill of this antidepressant. However, there is a complete dearth of medical information noted at the time of this previous request. Therefore, the medical necessity for this medication has not been established. Is also noted that this is a Serotonin-Norepinephrine Reuptake Inhibitor and is not recommended as a first-line intervention as tricyclic antidepressant are supported. Therefore, based on the clinical information presented for review this is not medically necessary and appropriate.

A RETROSPECTIVE REQUEST FOR TRAZODONE 50 MG #90 WITH ONE (1) REFILL WITH A DATE OF SERVICE OF 10/18/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 122 OF 127.

Decision rationale: The requested is for a retrospective refill of this antidepressant. However, there is a complete dearth of medical information noted at the time of this previous request. Therefore, the medical necessity for this medication has not been established. Is also noted that this is a Serotonin-Norepinephrine Reuptake Inhibitor and is not recommended as a first-line intervention as tricyclic antidepressant are supported. Therefore, based on the clinical information presented for review this is not medically necessary and appropriate.

A RETROSPECTIVE REQUEST FOR EFFEXOR XR 75 MG #60 WITH A DATE OF SERVICE OF 10/18/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-15.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 122 OF 127.

Decision rationale: The requested is for a retrospective refill of this antidepressant. However, there is a complete dearth of medical information noted at the time of this previous request. Therefore, the medical necessity for this medication has not been established. Is also noted that this is a Serotonin-Norepinephrine Reuptake Inhibitor and is not recommended as a first-line intervention as tricyclic antidepressant are supported. Therefore, based on the clinical information presented for review this is not medically necessary.

A RETROSPECTIVE REQUEST FOR TRAZODONE 100-150 MG #90 WITH A DATE OF SERVICE OF 10/18/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 122.

Decision rationale: The request is for a retrospective refill of this antidepressant. However, there is a complete dearth of medical information noted at the time of this previous request. Therefore, the medical necessity for this medication has not been established. It is also noted that this is a Serotonin-norepinephrine reuptake inhibitors (SNRI) and is not recommended as a first-line intervention as tricyclic antidepressants are supported. Therefore, based on the clinical information presented for review this is not medically necessary and appropriate.

A RETROSPECTIVE REQUEST FOR MEDICATION MANAGEMENT MONTHLY X 6 WITH A DATE OF SERVICE OF 10/18/2013: 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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 78.

Decision rationale: When noting the multiple medications being employed, there is a clinical indication for careful follow-up. However, when noting the date of injury, the most current findings on physical examination or lesser visits there is no clinical indication for monthly follow-up. As such, the medical necessity for this request is not been established in the records reviewed. The request is not medically necessary and appropriate.