

Case Number:	CM14-0002513		
Date Assigned:	01/22/2014	Date of Injury:	10/10/2011
Decision Date:	06/06/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	01/07/2014

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 Family Practice and is licensed to practice in Texas. 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 49 year old male who was injured on 10/10/2001 due to unknown mechanism. The clinical note dated 12/19/2013, indicated diagnoses of lumbar strain/sprain, facet syndrome, cervical sprain/strain, lumbosacral radiculopathy, wrist sprain, hand pain, shoulder sprain/strain; chronic pain syndrome, neck pain, hip pain, depression, situational due to medical condition, TFCC tear, discogenic pain, cervical radiculopathy, supraspinatus tenosynovitis, and De Quervains tenosynovitis. On physical exam, there was tenderness over the right wrist with reduced range of motion. The lumbar range of motion revealed greater pain on extension than on flexion, slightly kyphotic gait and a bit antalgic on the right. The injured worker had acute onset of right arm, right leg, hip left shoulder, back, thoracic, and neck pain following onset of depression post fall from ladder to the hard floor. The medication regimen included cyclogaba cream, effexor, flurbiprofen cream, hydrocodone, naproxen, orphenadrine and tramadol ER. The request for authorization was submitted on 11/25/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE EFFEXOR XR 37.5MG #30 FOR DOS 10/26/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Efexor (Venlafaxine)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 123.

Decision rationale: The injured worker diagnoses is lumbar strain/sprain, facet syndrome, cervical sprain/strain, lumbosacral radiculopathy, wrist sprain, hand pain, shoulder sprain/strain; chronic pain syndrome, neck pain, hip pain, depression, situational due to medical condition, TFCC tear, discogenic pain, cervical radiculopathy, supraspinatus tenosynovitis, and De Quervains tenosynovitis. The California Chronic Pain Medical Treatment Guidelines recommend Effexor as an option in first-line treatment of neuropathic pain. The guidelines also state it is a member of the selective-serotonin and norepinephrine reuptake inhibitor (SNRIs) class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. There is lack of evidence in the records to indicate neuropathic pain, the injured worker was diagnosed with depression and would benefit from the effexor. As such, per the guidelines the request for Effexor XR 37.5 #30 is not medically necessary.

RETROSPECTIVE HYDROCODONE 2.5/325MG #60 FOR DOS 10/26/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 89.

Decision rationale: The California Chronic Pain Medical Treatment recommend providing ongoing education on both the benefits and limitations of opioid treatment. The guidelines recommend the lowest possible dose should be prescribed to improve pain and function. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The documentation lacks evidence of this medication providing desired effects for the injured worker. There was a lack of an adequate and complete pain assessment within the documentation. As such, the request for Hydrocodone 2.5/325mg #60 is not medically necessary.