

<b>Case Number:</b>	CM14-0105210		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	03/03/2004
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	07/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2014

### 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 Physical Medicine and Rehabilitation and Pain Medicine 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 63-year-old male who reported an injury on 03/03/2004 due to an unknown mechanism. Physical examination dated 07/23/2014 revealed that the headache was always there. The injured worker uses Oxycodone 2 times a day for neck pain and low back pain. He also uses heating pads, hot tub, and Excedrin. It was noted that the injured worker was positive for depression and anxiety. It was reported that the primary care physician had tried to cover the injured worker's problems with depression and anxiety with 2 medications without benefit. Also, it was reported for the injured worker to do a stretching home exercise. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Effexor XR 75mg #30 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

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

**Decision rationale:** The decision for Effexor XR 75mg #30 with 3 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend

antidepressants as a first line medication for treatment of neuropathic pain, and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain, and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration, and psychological assessments. There was no objective functional improvement reported for sleep quality and duration and psychological assessments. There was no documentation of an objective decrease in pain and objective functional improvement. Also, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.