MAXIMUS Federal Services

Case Number:	CM14-0037247		
Date Assigned:	06/25/2014	Date of Injury:	07/01/1997
Decision Date:	07/25/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	03/27/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 59-year-old female with a 7/1/97 date of injury and status post transposition of right ulnar nerve 9/02. At the time (3/12/14) of request for authorization for Venlafaxine HCL ER 150 mg #30 and gabapentin 300 mg #90, there is documentation of subjective (bilateral upper extremity pain) and objective (restricted shoulder movements, tenderness, dysesthesias of right 4th and 5th digits, hypersensitive to light touch) findings, current diagnoses (reflex sympathetic dystrophy upper limb, ulnar neuropathy, shoulder pain, and mood disorder).Treatment to date (stellate ganglion blocks, spinal cord stimulator, activity modification, physical therapy, and medications (including Venlafaxine HCL ER and gabapentin (since at least 1/11)). Regarding the requested Venlafaxine HCL ER 150 mg #30, there is no documentation of trial of first line agent tricyclics antidepressants unless they are ineffective, poorly tolerated, or contraindicated. Regarding the requested gabapentin 300 mg #90, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of gabapentin use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Venlafaxxine Hcl ER 150mg #30: 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 < Antidepressants for chronic pain Page(s): 13-14.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain, as criteria necessary to support the medical necessity of antidepressants. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies tricyclics antidepressants as first-line agent unless they are ineffective, poorly tolerated, or contraindicated. ODG identifies documentation of depression, as criteria necessary to support the medical necessity of antidepressants. Within the medical information available for review, there is documentation of diagnoses of reflex sympathetic dystrophy upper limb, ulnar neuropathy, shoulder pain, and mood disorder. In addition, there is documentation of chronic pain. However, there is no documentation of trial of first line agent tricyclics antidepressants unless they are ineffective, poorly tolerated, or contraindicated. Therefore, based on guidelines and a review of the evidence, the request for Venlafaxxine HCL ER 150 mg #30 is not medically necessary.

Gabapentin 300mg #90: 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 Gabapentin (Neurontin) Page(s): 18-19.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of reflex sympathetic dystrophy upper limb, ulnar neuropathy, shoulder pain, and mood disorder. In addition, there is documentation of neuropathic pain. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of gabapentin use to date. Therefore, based on guidelines and a review of the evidence, the request for gabapentin 300 mg #90 is not medically necessary.