

Case Number:	CM14-0074080		
Date Assigned:	07/16/2014	Date of Injury:	09/30/1993
Decision Date:	10/01/2014	UR Denial Date:	04/24/2014
Priority:	Standard	Application Received:	05/21/2014

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 Occupational 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 patient is a 61 year old male who was injured on 09/30/1993. The mechanism of injury is unknown. His medications as of 12/13/2013 included Tramadol 50 mg; Gabapentin 600 mg; Celebrex 100 mg; Venlafaxine Hcl 150 mg; and Omeprazole 20 mg. The patient underwent right L4 and right L5 transforaminal epidural steroid injection on 11/13/2013, which provided him with temporary relief. Diagnostic studies reviewed include MRI of the lumbar spine dated 09/19/2012 revealed chronic lumbar radiculopathy. Office visit note dated 12/13/2013 documented the patient to have complaints of back pain. On exam, Romberg sign is negative. Shoulder range of motion is limited in forward flexion by 50%. He has pain with testing of his rotator cuff on the right side. He is diagnosed with right L4 and L5 radiculopathy; opioid tolerance; axial low back pain and right shoulder pain secondary to rotator cuff injury. Prior utilization review dated 04/24/2014 states the request for Celebrex 100 Mg, #30, 3 Refills is modified to certify Celebrex 100 mg #30 no refills; Trazodone 50 Mg, #60, 3 Refills is modified to certify Trazodone 50 mg #30 with no refills; Venlafaxine HCL ER, #30, 3 Refills is modified to certify Vanlafaxine HCL ER #30 with no refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 100 mg, #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 22, 68 and 70.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: According to MTUS guidelines, NSAIDs are recommended as an option for short-term symptomatic relief of low back pain. In this case a request is made for Celebrex for a 61-year-old male injured on 9/30/93 with chronic low back pain. However, the patient is prescribed Celebrex on a chronic basis without evidence or discussion of functional improvement or pain reduction in the provided medical records. Therefore, the request of Celebrex 100 mg, #30 with 3 refills is not medically necessary and appropriate.

Trazodone 50 mg, #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines, 12th edition, pain

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress, Trazodone

Decision rationale: MTUS guidelines do not address the request. According to ODG guidelines, Trazodone is "recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety." In this case Trazodone is prescribed as needed for insomnia. However, there is no discussion in the provided records of response to treatment or comorbid psychiatric conditions. As such, Trazodone 50 mg, #60 with 3 refills is not medically necessary and appropriate.

Venlafaxine HCL ER, #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines citation not given Page(s): 123.

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

Decision rationale: According to MTUS guidelines, Venlafaxine is "recommended as an option in first-line treatment of neuropathic pain." In this case a request is made for Venlafaxine for a 61-year-old male injured on 9/30/93 with chronic low back pain and radiculopathy confirmed by electrodiagnostic testing. The patient is presumably prescribed this medication for neuropathic pain as there is no discussion of psychiatric disorder. However, there is no discussion of response to treatment. The patient is noted to have failed medications, and a functional restoration program is requested. Therefore, the Venlafaxine HCL ER, #30 with 3 refills is not medically necessary and appropriate.