

<b>Case Number:</b>	CM15-0181184		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	10/10/2002
<b>Decision Date:</b>	10/27/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 66 year old female, who sustained an industrial injury on 10-10-2002. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for degenerative joint disease of the bilateral knees, low back pain and degenerative lumbar disk disease. Medical records (04-20-2015 to 06-01-2015) indicate ongoing low back pain and bilateral knee pain. Pain levels were not provided. Records also indicate no changes in activity or daily functioning. Per the treating physician's progress report (PR), the IW has not returned to work. The physical exam, dated 06-01-2015, revealed no objective findings. The previous exam reported patellar facet tenderness to both knees. Relevant treatments have included left knee arthroplasty (2012), right knee arthroplasty (2013), physical therapy (PT), work restrictions, and medications (Venlafaxine since at least 04-2015). The treating physician indicates that x-rays of the knees showing satisfactory positioning of the previous arthroplasty. No request for authorization was available for review; however, the utilization review states that the request was received on 09-01-2015 and that the following medication was requested: Venlafaxine XR 75mg #90 with 2 refills. The original utilization review (09-03-2015) partially approved the request for Venlafaxine XR 75mg #90 with 2 refills (modified to 1 prescription without refills) based on lack of documented response to the medication's prior use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Venlafaxine XR 75 mg #90 with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Venlafaxine (Effexor). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Anti-depressants.

**Decision rationale:** Key case observations are as follows. The claimant was injured in 2002 with degenerative joint disease of the bilateral knees, low back pain and degenerative lumbar disk disease. Medical records from April to June 2015 indicate ongoing low back and bilateral knee pain. The original utilization review from 9-03-2015 partially approved the request for Venlafaxine XR 75mg #90 with 2 refills to 1 prescription without refills, based on lack of documented response to the medication's prior use. The current California web-based MTUS collection was reviewed in addressing this request. The ODG was also examined and used. Regarding anti-depressants to treat a major depressive disorder, the ODG notes: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. In this case, it is not clear what objective benefit has been achieved out of the anti-depressant usage, how the activities of daily living have improved, and what other benefits have been. It is not clear if this claimant has a major depressive disorder as defined in DSM-IV. If used for pain, it is not clear what objective, functional benefit has been achieved. The request is not medically necessary and appropriately non-certified.