

<b>Case Number:</b>	CM15-0129143		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	07/25/2012
<b>Decision Date:</b>	08/13/2015	<b>UR Denial Date:</b>	06/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2015

### 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, California  
 Certification(s)/Specialty: Family Practice

### 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 57 year old male, who sustained an industrial injury on 7/25/12. The injured worker has complaints of chronic left shoulder pain. The documentation on 4/29/15 noted that the injured worker has an injury to his right shoulder; however, this has not been accepted as an industrial claim. The documentation noted that atrophy is present in right upper extremity and 4/5 strength. The diagnoses have included pain in joint shoulder. The patient had complaints of numbness and weakness and had history of depression. Treatment to date has included acupuncture; physical therapy; flexeril; diclofenac; protonix; capsaicin cream; venlafaxine; amlodipine; norco; gabapentin and ibuprofen and upper left back/left shoulder surgery on 11/26/12. The request was for retrospective capsaicin 0.075% cream quantity 1.00 (date of service 04/29/2015) and retrospective venlafaxine HCL ER 37.5mg quantity #120 (date of service 04/29/2015). The medication list include flexeril; diclofenac; protonix; capsaicin cream; venlafaxine; amlodipine; norco; gabapentin and ibuprofen. The patient's surgical history include upper left back and left shoulder surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Capsaicin 0.075% cream Qty: 1.00 (DOS 04/29/2015): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain-Topical Analgesics, pages 111-112 Topical Analgesics.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines regarding topical analgesics state that the use of topical analgesics is "Largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed". "MTUS guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. The medication list contains Gabapentin. The detailed response of the gabapentin for this injury was not specified in the records provided. Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments". Any intolerance or contraindication to oral medications was not specified in the records provided. Any evidence of diminished effectiveness of medications was not specified in the records provided. The medical necessity of the medication Retro Capsaicin 0.075% cream Qty: 1.00 DOS 04/29/2015 is not fully established in this patient. Therefore, the request is not medically necessary.

**Retro Venlafaxine HCL ER 37.5mg Qty: 120 (DOS 04/29/2015): Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page 13Antidepressants for chronic pain page 14.

**Decision rationale:** Venlafaxine (Effexor): FDA-approved for anxiety, depression, panic disorder and social phobias. Off-label use for fibromyalgia, neuropathic pain, and diabetic neuropathy. Effexor XR contains venlafaxine hydrochloride Venlafaxine (brand name: Effexor or Efexor) is an antidepressant. According to the cited guidelines indications for Effexor include neuropathic pain. The injured worker has complaints of chronic left shoulder pain. The documentation on 4/29/15 noted that the injured worker has an injury to his right shoulder. The documentation noted that atrophy is present in right upper extremity and 4/5 strength. The diagnoses have included pain in joint shoulder. The patient had complaints of numbness and weakness and had history of depression. The patient has had history of upper left back/left shoulder surgery on 11/26/12. The patient has evidence of chronic pain along with depression. The request for Retro Venlafaxine HCL ER 37.5mg Qty: 120 (DOS 04/29/2015) is medically necessary and appropriate for this patient.