

<b>Case Number:</b>	CM14-0048144		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	03/03/2009
<b>Decision Date:</b>	08/26/2014	<b>UR Denial Date:</b>	04/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2014

### 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 56-year-old male who has submitted a claim for chronic posttraumatic stress disorder, severe single episode major depression, and generalized anxiety disorder associated with an industrial injury date of March 3, 2009. Medical records from 2013-2014 were reviewed. The patient complained of residual psychiatric and chronic pain symptoms as a consequence of his work injury. His symptoms of PTSD include distressing intrusive memories of the accident, nightmares, flashbacks, hypervigilance, exaggerated startle response, and avoidance of people, places and things which remind him of the accident. His depression symptoms include depressed mood, anhedonia, sleep and appetite disturbance, low energy, feelings of helplessness and hopelessness, and impaired concentration. He has also been suffering from symptoms of generalized anxiety disorder like excess worrying, muscle tension, sleep problems, shakiness, and fatigue. His activities of daily living were limited, and he tends to be socially avoidant and reclusive. Physical examination showed a PHQ-9 depression score of 8 indicative of mild to moderate depression. Imaging studies were not available for review. Treatment to date has included medications, psychotherapy, activity modification, right knee surgery, and knee Orthovisc injections. Utilization review, dated April 1, 2014, denied the requests for medication refill because the patient's dose, frequency, quantity and specific names of medications were not clarified; and functional restoration program evaluation because he is considered a likely candidate for total knee replacement, has had 5 years of disability, has high levels of psychological distress related to chronic PTSD and depression, and does not have a significant loss of ability to function independently.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Medication Refill:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Medications for Subacute and Chronic Pain.

**Decision rationale:** The California MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Pain Section was used instead. It states that relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. In this case, progress report dated March 24, 2014 stated that the patient is on Viibryd, Zolpidem, Silenor, Lorazepam, Gabapentin, Flector patch, Vothyroxin, Metoprolol, Allopurinol, Lovastatin, and Norco. The present request failed to specify the particular medications as well as the dose, frequency and amount to be refilled for this patient. The medical necessity has not been established due to non-specificity of the request. Therefore, the request for Medication Refill is not medically necessary.

**Functional Restoration Program Evaluation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration program) Page(s): 30-32.

**Decision rationale:** According to pages 30-32 of the California MTUS Chronic Pain Medical Treatment Guidelines, functional restoration program (FRP) participation may be considered medically necessary when all of the following criteria are met: (1) an adequate and thorough evaluation including baseline functional testing was made; (2) previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) there is significant loss of ability to function independently; (4) the patient is not a candidate where surgery or other treatments would clearly be warranted; (5) the patient exhibits motivation to change; and (6) negative predictors of success have been addressed. In this case, the patient was diagnosed with chronic posttraumatic stress disorder, severe single episode major depression, and generalized anxiety disorder. Rationale for the present request was not provided. The medical records did not provide an adequate and thorough evaluation of the chronic pain, and baseline functional testing was also not performed. There was

no documentation regarding failure of other treatments. Furthermore, there was also no discussion regarding absence of other options that are likely to result in improvement of the patient's condition. In addition, there was also no evidence of failed return to work attempts or significant loss of ability of the patient to function independently. Moreover, negative predictors of success were not addressed. The criteria have not been met. Therefore, the request for Functional Restoration Program Evaluation is not medically necessary.