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| Case Number: | CM14-0185065 | | |
| Date Assigned: | 11/12/2014 | Date of Injury: | 05/30/2011 |
| Decision Date: | 01/28/2015 | UR Denial Date: | 10/31/2014 |
| Priority: | Standard | Application Received: | 11/06/2014 |

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 applicant is a represented [REDACTED] employee who has filed a claim for chronic pain syndrome reportedly associated with an industrial injury of May 30, 2011. In a Utilization Review Report dated October 30, 2014, the claims administrator failed to approve a request for a functional restoration program evaluation. The applicant was status post earlier shoulder surgery and had reportedly developed issues with reflex sympathetic dystrophy, the claims administrator noted. The claims administrator's rationale was somewhat incongruous as, in one section of its note, it posited that there was no evidence that the applicant had a significant loss of ability to function as a result of her chronic pain while at the top of the report it stated that the applicant was "disabled." The claims administrator referenced progress notes of October 2, 2014 and October 14, 2014 in its denial. The applicant's attorney subsequently appealed. In an April 24, 2014 progress note, the applicant reported ongoing issues with neck pain, arm pain, headaches, and psychological stress. The applicant was status post shoulder surgery in 2012. The applicant reported issues with depression and anxiety. The applicant was angry at the outcome of the earlier failed shoulder surgery and shoulder corticosteroid injection. The applicant was given diagnoses of chronic pain syndrome, major depressive disorder, and generalized anxiety disorder. Cognitive behavioral therapy was endorsed. On May 16, 2014, the applicant reported 7/10 neck and shoulder pain with ancillary complaints of depression and anxiety interfering with her ability to cook, drive, and perform housekeeping activities. The applicant apparently had comorbid hypertension. The applicant was status post shoulder surgery in May 2013, it was stated on this occasion. The applicant was on Ambien, Cymbalta, diclofenac, Neurontin, Norco, and Percocet. Chiropractic manipulative therapy and psychology were sought while Norco and Ambien were refilled. The applicant's work status was not outlined, although it did not appear that the applicant was working. On October 14, 2014, the

applicant reported ongoing complaints of neck and shoulder pain, 9/10, with attendant complaints of depression, anxiety, and emotional disturbance. The applicant stated that her pain complaints were impacting her ability to cook, drive, and perform housekeeping activities. The applicant was temporarily disabled, it was stated in the social history section of the note. The applicant's BMI was 29. Norco was refilled. A multidisciplinary evaluation for pain management program was sought on the grounds that the applicant had failed physical therapy, chronic pain psychology, corticosteroid injection therapy, and medication trials. The attending provider stated that he was trying to determine whether the applicant could be rehabilitated or not. The applicant's medication list reportedly included Ambien, Neurontin, Norco, and Nucynta, it was stated in one section of the note, although the list was truncated. On October 23, 2014, the applicant reported ongoing issues with depression and anxiety. The applicant was given a Global Assessment of Function (GAF) of 41, suggestive of severe depression. The applicant only took Paxil for one night, developed a headache, and felt that she could not tolerate the same. The applicant stated that she was very tearful and having difficulty with decision making. The applicant's psychiatrist stated that he would introduce Remeron and formally discontinue Paxil. Additional cognitive behavioral therapy was again sought.

IMR ISSUES, DECISIONS AND RATIONALES

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

Initial Evaluation for a Functional Restoration Program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Intractable Pain; Chronic Pain Programs Page(s): 6; 32.

Decision rationale: While page 6 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that an evaluation for admission into a functional restoration program should be considered in applicants who are prepared to make the effort to try and improve, in this case, however, it was not clearly or specifically stated that the applicant was in fact prepared to make the effort to try and improve. It was not clearly stated that the applicant was willing to forego disability or indemnity benefits in an effort to try and improve. Furthermore, page 32 of the MTUS Chronic Pain Medical Treatment Guidelines stipulates that one of the cardinal criteria for admission into a functional restoration program is evidence that previous methods of treating chronic pain have proven unsuccessful and there is an absence of other options likely to result in significant improvement. Here, however, the applicant was started on Remeron on October 23, 2014, i.e., approximately 10 days after the functional restoration program evaluation was sought on October 14, 2014. The applicant's depression was described as severe as of October 23, 2014. The applicant's psychiatrist acknowledged that the applicant's psychotropic medications management was suboptimal at best and made changes on that date. Thus, there does not appear to be an absence of other options likely to result in significant clinical improvement here as optimization of the applicant's psychotropic medications could theoretically result in significant improvement. Therefore, the request is not medically necessary.