MAXIMUS Federal Services

Case Number:	CM15-0174327		
Date Assigned:	09/16/2015	Date of Injury:	05/12/2011
Decision Date:	10/16/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	09/04/2015

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:

This injured worker is a 63 year old male who reported an industrial injury on 5-12-2011. His diagnoses, and or impression, were noted to include: arthropathy of lower leg; chronic pain syndrome; skin sensation disturbance. No current imaging studies were noted. His treatments were noted to include: diagnostic x-rays; ice and heat therapies; exercises; pain management with toxicology screenings; and a return to full work duties. The progress notes of 7-9-2015 reported complaints of unchanged lower back pain and right knee pain, rated 7 out of 10, which radiated to the right ankle, was aggravated by activity, and was relieved by medication and rest; that he continued to have pain symptoms on a regular basis that was adequately managed by his current medications. Objective findings were noted to include: his appearance of anxiety and depression; a right-sided antalgic gait; crepitus, pain and restricted range-of-motion in the right knee joint; numbness, tingling and weakness in the bilateral lower extremities. The physician's requests for treatments were noted to include the switching to Buspirone 7.5 mg twice a day, #60, 1 day prior by a different doctor, with cautioning for this injured worker to monitor for potential adverse effects such as spasms and depression. The Request for Authorization (RFA), dated 7-14-2015, included a refill for Buspirone Hcl 7.5 mg #60. The Utilization Review of 8- 14-2015 modified the request for Buspirone HCL tablets 7.5 mg twice a day, #60, to #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Buspirone Hcl 7.5mg twice a day #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA 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 chapter, under Antidepressants.

Decision rationale: This claimant was injured in 2011 with arthropathy of lower leg; chronic pain syndrome; skin sensation disturbance. As of July, there is unchanged lower back pain and right knee pain. There was an appearance of anxiety and depression. The Utilization Review of 8- 14-2015 modified the request for Buspirone HCL tablets 7.5 mg twice a day, #60, to #30. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Regarding antidepressants 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 antidepressant 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. There was an appearance of depression, but no actual DSM analysis and confirmation of a diagnosis. The request is appropriately non-certified.