

Case Number:	CM13-0047524		
Date Assigned:	12/27/2013	Date of Injury:	02/16/1993
Decision Date:	02/28/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	11/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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 physician 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 reported an injury on 02/16/1993. The mechanism of injury was not submitted. The patient was diagnosed with postlaminectomy syndrome, lumbosacral radiculitis, and lumbago. The patient complained of back pain with pain in the feet. The patient was seen for pharmacological re-evaluation, intrathecal pump analysis, and refill and reprogramming. The patient reported that he greatly missed his spinal cord stimulator. The patient reported burning and numbness in the lower extremities, especially in the feet. The patient reported the intrathecal pump was very helpful. The patient reported that his psychiatrist had fallen ill. The patient had not seen his psychiatrist for 3 months and another psychiatrist who was covering for the practice could not see the patient for another 3 months. The covering psychiatrist would not order the patient's medications. The patient had been stable on Remeron 15 mg per day and Cymbalta 30 mg twice a day. The patient's medications included Alprazolam 0.5 mg, Ambien CR 12.5 mg, Carvedilol 12.5 mg, Crestor 10 mg, Effexor XR 75 mg 1 capsule every morning, Fenofibrate 200 mg, Lisinopril 10 mg, Lovaza, OxyContin 40 mg 1 tablet every 8 hours, Remeron 45 mg, and Tizanidine 4 mg 3 times a day. The patient had decreased range of motion with the cervical spine with pain. The treatment plan included continuation of OxyContin 40 mg, Remeron, Cymbalta, intrathecal pain pump refill, and request that the spinal cord simulator system be implanted using surgical paddle leads from the low back to cover the legs by his neurosurgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medication monitoring every 3 months as outpatient, #4: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

Decision rationale: California MTUS recommend office visits every 1 ½ months to 2 months while a patient is taking opioids during the first 6 months. According to the California Medical Board Guidelines for Prescribing Controlled Substances for Pain, patients with pain who are managed with controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care. The patient complained of back pain with burning in the feet; however, the documentation states the patient has been stable on his medication. Therefore, more frequent office visits would not be needed and medication management visits once every 3 months would be considered standard of care for a patient on OxyContin. Given the above, the request is certified.