

<b>Case Number:</b>	CM15-0113397		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	05/23/2000
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	05/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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:

The injured worker is a 49 year old female with an industrial injury dated 05/03/2000. Her diagnoses included displacement of lumbar intervertebral disc, post laminectomy syndrome - lumbar region, chronic pain syndrome and long term (current) drug use. Prior treatment included surgery and medications. She presents on 05/11/2015 for a follow up visit. The provider notes because of the pain the injured worker had an episode of severe spasm requiring a trip to the emergency room. Her current medications were Baclofen, Norco, Lidoderm, Zolpidem, Benicar, Bupropion, Effexor XR and Estradiol. Treatment plan included physical therapy, medial branch block, baclofen, return to refill clinic on a monthly basis and return for a follow up in six weeks. In the progress note dated 05/05/2015 the provider documents the patient reports analgesia from medication, increased activities of daily living, denies any adverse effects, shows no evidence of aberrant drug taking behaviors and shows appropriate affect. Her urine drug testing was in compliance with HELP risk stratification procedure on 03/05/2015. CURES report dated 05/05/2015 showed no alternate prescribers or duplicate prescriptions. The treatment request is return to refill clinic on monthly basis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Return to refill clinic on monthly basis:** 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, Office visits.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): 7-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain- Office visits.

**Decision rationale:** Return to refill clinic on monthly basis is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines and the ODG. The MTUS states that whether the treatment is provided by an individual provider, a multidisciplinary group of providers, or tightly integrated interdisciplinary pain program, it is important to design a treatment plan that explains the purpose of each component of the treatment. Furthermore, demonstration of functional improvement is necessary at various milestones in the functional restoration program in order to justify continued treatment. The ODG states that the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The documentation does not indicate extenuating circumstances which would necessitate refills monthly without a specified duration and evidence of efficacy of medications to justify continued refills. This request is therefore not medically necessary.