

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 11/19/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	6/8/2013
Date of Injury:	12/6/2007
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004099

- 1) MAXIMUS Federal Services, Inc. has determined the request for **implantation/replacement of device for intrathecal or epidural drug infusion is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **programmable pump, including preparation of pump with or without programming is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 6/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **implantation/replacement of device for intrathecal or epidural drug infusion programmable pump, including preparation of pump with or without programming) is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The patient is a 38-year-old male who reported a work-related injury on 12/06/2007; mechanism of injury was result of a fall. the patient presents with complaints of bilateral shoulder, bilateral arm, cervical spine pain, and bilateral upper extremity reflex sympathy, pain to the shoulder region, mechanical neck pain, cervical facet arthropathy, and status post right shoulder arthroscopic surgery in 2008. The patient's medication regimen includes Tylenol/codeine No. 3, tramadol, and Flexeril. The patient had utilized lower levels of conservative treatment, to include TENS, heat/ice, physical therapy, pain medications, and surgery without benefit of his pain complaints. The patient underwent an intrathecal trial of morphine in 02/2012, which provided 80% relief of the patient's pain complaints. The clinical note dated 01/21/2013 reported the patient underwent a pain management follow-up visit under the care of Dr. [REDACTED]. The provider documented the patient has reported swelling and discolorations to his bilateral hands. The provider documented the patient underwent a successful intrathecal pump trial and has been awaiting authorization for intrathecal pump implantation. The provider documents the patient had been trialed with utilization of Exalgo to control his pain; however, this caused adverse side effects, such as nausea and vomiting and was discontinued after the third dose. The provider documented the patient reports continued pain and discomfort of the bilateral upper extremities. The provider documented upon physical exam of the patient's bilateral hands and wrists noted to be swollen and discolored with limited range of motion of the shoulders. The patient's fingers were noted to appear "like sausages." The provider documented objectively the patient had swelling, discoloration of the bilateral hands, wrists, limited range of motion of the bilateral shoulders, swelling of the fingers, and reported pain and discomfort to the bilateral upper extremities.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from (Claims Administrator, employee/employee representative)
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for implantation/replacement of device (programmable pump, including preparation of pump with or without programming) for intrathecal or epidural drug infusion :**Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, (2009), pages 53-54, which are part of the California Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, (2009), pages 53-54, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The records submitted and reviewed lack documentation of the employee having failed a trial of several other opioids, in particular long-acting opioids, as recommended prior to consideration of permanent implantation of an intrathecal pump for analgesic relief. This is also true of non-opioid analgesics, as only Flexeril was documented for this employee. Further, there is no documentation of failure of physical modalities of a home exercise program or strengthening and conditioning program. In addition, there is a lack of documentation evidencing a psychological evaluation has been performed to rule out evidence of inadequately controlled mental health problems and determination of no contraindications prior to intrathecal drug delivery. A single injection of intrathecal morphine 16 months ago resulted in 80% relief reported but no procedure note was available. A psychological evaluation dated 4/5/2013 reports the employee presents with pain that is not psychological in origin. However, the clinical notes lack evidence of the employee exhausting oral analgesics for pain complaints, such as long-acting opioids. **The request for implantation/replacement of device (programmable pump, including preparation of pump with or without programming) for intrathecal or epidural drug infusion is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/sab

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.