

Case Number:	CM13-0031303		
Date Assigned:	12/18/2013	Date of Injury:	09/21/2008
Decision Date:	03/06/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	10/03/2013

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 and Rehabilitation and is licensed to practice in Illinois. 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 64-year-old male who reported a work-related injury on September 21, 2008. The specific mechanism of injury was not stated. The patient presents for treatment of the following diagnoses: lumbar disc degeneration, lumbar facet arthropathy, low back pain, sciatica, lumbar radiculopathy, post-laminectomy syndrome of the lumbar spine, and chronic pain syndrome with psychosocial dysfunction. The patient underwent a spinal cord stimulator trial on March 05, 2013. The clinical note dated March 11, 2013 documented that the patient was unable to endure the spinal cord stimulator trial due to scar tissue around the spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intrathecal pain pump trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 53-54. Decision based on Non-MTUS Citation ODG, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems (IDDSs) Page(s): 53-54.

Decision rationale: The California MTUS states that implantable infusion pumps are considered medically necessary when used to deliver drugs for the treatment of: Primary liver cancer; Metastatic colorectal cancer where metastases are limited to the liver; Head/neck cancers;

Severe, refractory spasticity of cerebral or spinal cord origin in patients who are unresponsive to or cannot tolerate oral baclofen (Lioresal®) therapy. Guidelines also recommend permanently implanted intrathecal (intraspinal) infusion pumps for the administration of opiates or non-opiate analgesics, in the treatment of chronic intractable pain, are considered medically necessary when: Used for the treatment of malignant (cancerous) pain or Used for the treatment of non-malignant (non-cancerous) pain with a duration of greater than 6 months when all lower levels of conservative treatment has failed. The clinical documentation submitted for review lacks evidence of the patient having utilized recent lower levels of conservative treatment for his multiple bodily injury pain complaints. Furthermore, the clinical notes evidence the patient may still be a surgical candidate for decompressive surgery at the L3-4 level as well a right total knee replacement. The timing of this requested intervention is not supported. Given all the above the request for is not medically necessary or appropriate.

one (1) Day Length of Stay (LOS): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter

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.

Decision rationale: As the requested operative procedure is not indicated at this point in the patient's treatment, the request for a one (1) Day Length of Stay (LOS) is not medically necessary or appropriate.