

<b>Case Number:</b>	CM14-0002696		
<b>Date Assigned:</b>	01/29/2014	<b>Date of Injury:</b>	12/10/1993
<b>Decision Date:</b>	06/16/2014	<b>UR Denial Date:</b>	12/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and 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 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/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 51 year old male injured on 12/10/93 due to undisclosed mechanism of injury. The patient received routine evaluations and pain management for chronic lumbar pain, recurrent myofascial strain, radicular pain in the lower extremities. The patient was status post lumbar spine fusion at three levels and diagnosed with failed lumbar back surgery syndrome with intermittent exacerbations of neuropathic pain and myofascial strain. Medication management included ibuprofen, Senokot, Norco 325-10mg Q46 hours with a max of five per day, and AndroGel 1%. The patient also required intrathecal pain pump placement with morphine 0.7mg per/day and bupivacaine 3.5mg/day. The patient reported constant low back pain radiating to the left leg rated at 7/10 with 30% reduction in pain from intrathecal pain medications. The patient reported good pain control from current opioid pain medications, increased physical activity, increase in activities of daily living, and increase in mood and sleep. There were inconsistent drug screens noted in the clinical documentation. 8 pump refills and maintenance from January 1, 2014 to June 30, 2014 for Lumbar Spine have been requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **REQUEST FOR 8 PUMP REFILLS AND MAINTENANCE FROM JANUARY 1, 2014 TO JUNE 30, 2014 FOR LUMBAR SPINE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Intrathecal Pumps..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Intrathecal Drug Delivery Systems, Medications, Page(s): 54.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, Intrathecal drug delivery systems are appropriate for the management of intractable pain. It appears from the documentation that the patient is being monitored appropriately and medications are being administered adequately. However, a request for 8 pump refills is excessive. The patient is being evaluated on a monthly basis and his status and that of the pump and medication requirements may change. As such, the request for Request For 8 Pump Refills And Maintenance From January 1, 2014 To June 30, 2014 For Lumbar Spine cannot be recommended as medically necessary.