MAXIMUS Federal Services

Case Number:	CM14-0006245		
Date Assigned:	06/11/2014	Date of Injury:	08/19/1994
Decision Date:	08/01/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/14/2014

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 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 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 injured worker is a 53-year-old male who reported an injury on 08/19/1994. The mechanism of injury was not provided for clinical review. Previous treatments included CT, medications, physical therapy, home exercise, and a pain pump. Diagnoses included failed back surgery syndrome, lumbar radiculopathy, and sprain/strain of the lumbosacral region. In the clinical note dated 10/29/2013, it reported the injured worker's lumbar radiculopathy is controlled with IT opioids in his pain pump. The injured worker's pain pump is 6 years old. On physical examination, the provider noted tenderness to palpation of the lumbosacral spine at L4-5. The provider indicated the injured worker had bilateral paralumbar tenderness. The range of motion of flexion was at 65 degrees and hyperextension at 25 degrees. The provider indicated the injured worker had bilateral lumbar spasms. The injured worker had decreased sensation in the right L5 and decreased sensation in the left L5. The provider indicated the injured worker's deep tendon reflexes in the lower extremities were normal bilaterally. The provider indicated the injured worker's IT pump was found to be working normally. The provider requested an IT pain pump replacement prior to battery depletion. The Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain pump replacement lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable Drug-Delivery Systems Page(s): 52-54.

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

Decision rationale: The California MTUS Guidelines note pain pumps are used for treatment of non-malignant pain with a duration of greater than 6 months and all of the following criteria: (1) the documentation in the medical record of failure of 6 months of other conservative treatment modalities, including medication, surgery, psychological, or physical, if appropriate and do not contraindicate; (2) intractable pain secondary to a disease state with objective documentation of pathology in the medical record; (3) further surgical intervention or other treatment is not indicated or likely to be effective; (4) psychological evaluation has been obtained and evaluations state that the pain is not primarily psychologic in origin, and that benefit would occur with implantation despite any psychiatric comorbidity; (5) no contraindications to implantation exist, such as sepsis or coagulopathy; (6) a temporary trial of spinal epidural or intrathecal opioids have been successful prior to the permanent placement as defined by at least 50% to 70% reduction in pain, and documentation in the medical record of functional improvement and associated reduction in oral pain medication use. A temporary trial of intrathecal infusion pumps is considered medically necessary only when the criteria above have been met. In this case, there is a lack of significant objective findings indicating the injured worker has had 50% to 70% reduction in pain and documentation of functional improvement. The clinical documentation submitted indicated the provider documented the injured worker's IT was functioning normally. Furthermore, there is a lack of significant documentation warranting the medical necessity for a replacement pain pump. Therefore, the request for a pain pump is not medically necessary and appropriate.