

<b>Case Number:</b>	CM14-0102503		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	08/05/1957
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2014

### 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 Nevada. 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 57 year-old male who was reportedly injured on September 4, 1993. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated June 29, 2014, indicates that there are ongoing complaints of chronic pain. The physical examination was not presented and an explanation of why the ongoing utilization of such a device is necessary was presented. Diagnostic imaging studies objectified disc desiccation, facet hypertrophy, foraminal impingement throughout the lumbar spine. Previous treatment includes intrathecal pain pump, multiple lumbar surgeries, physical therapy and multiple narcotic medications. A request was made for intrathecal pump and was not certified in the pre-authorization process on June 13, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Intrathecal Pump replacement:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug delivery systems.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**Decision rationale:** After failing to provide the appropriate clinical information, the letter of clarification dated June 29, 2014 addresses each of the items listed in the California Medical Treatment Utilization Schedule relative to the treatment of nonmalignant pain and the use of intrathecal drug delivery systems. Each of the 6 criterion are noted to be met, the injured employee has return to work and continues to function at acceptable levels. Therefore, based on the additional clinical information not previously presented there is a medical necessity for the ongoing use of this device.

**Revision of catheter:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug delivery systems.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**Decision rationale:** With the additional clinical information now presented, there is a clinical indication to revise the device. Therefore, this is medically necessary.

**Hardware-pump system:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug delivery system.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**Decision rationale:** With the additional clinical information now presented, there is a clinical indication to revise the device. Therefore, this is medically necessary.

**Pre-op lab-Metabolic panel:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**Decision rationale:** With the additional clinical information now presented, there is a clinical indication to revise the device. Therefore, this is medically necessary.

**Pre-op lab-Complete Blood Count (CBC):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**Decision rationale:** With the additional clinical information now presented, there is a clinical indication to revise the device. Therefore, this is medically necessary.

**Pre-op lab-Hematocrit (HCT):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**Decision rationale:** With the additional clinical information now presented, there is a clinical indication to revise the device. Therefore, this is medically necessary.

**Pre-op lab-Hemoglobin (HGB):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**Decision rationale:** With the additional clinical information now presented, there is a clinical indication to revise the device. Therefore, this is medically necessary.

**Electrocardiogram (EKG):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**Decision rationale:** With the additional clinical information now presented, there is a clinical indication to revise the device. However, there is no suggestion of any cardiac disease. This

protocol is not clinically indicated based on the clinical information presented for review. Therefore, this request is not medically necessary.

**Chest X-ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**Decision rationale:** With the additional clinical information now presented, there is a clinical indication to revise the device. However, there is no suggestion of any pulmonary disease. This protocol is not clinically indicated based on the clinical information presented for review. Therefore, this request is not medically necessary.

**Nasal Polymerase Chain Reaction (PCR) test for Methicillin-resistant Staphylococcus aureus (MRSA):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52.

**Decision rationale:** With the additional clinical information now presented, there is a clinical indication to revise the device. However, there is no suggestion of any cardiac disease. This protocol is not clinically indicated based on the clinical information presented for review. Therefore, this request is not medically necessary.

**Molecular pathology procedure (opiates):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Cytokine DNA testing

**Decision rationale:** When noting the past treatment, and that this drug delivery device has been in place for a number of years, the limited medical records that are for review with all for a clinical indication or literature support for such testing. Therefore, the medical necessity cannot be established.

