

<b>Case Number:</b>	CM14-0116983		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	10/09/2008
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	07/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2014

### 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 patient is a 58 year old female who was injured on 10/09/2008. The mechanism of injury is unknown. Prior medication history included Dobutrex, MS-Contin, oxycodone, marijuana, tricyclic anti-depressants and Norco. Prior treatment history has included physical therapy, epidural steroid injections. Progress report dated 06/30/2014 states the patient presented for a follow up of her chronic pain in the lower back and bilateral lower extremities as well as pain in the right shoulder and right upper extremity. She rated her pain as 8/10 at its worst and 6/10 at its best. Objective findings on exam revealed lumbar range of motion exhibits flexion at 50%; extension at 50%; bilateral lateral bending at 75%; bilateral rotation at 75% all with pain in the low back. There is tenderness to palpation at L3-S1 bilaterally. Motor strength is 5/5 in all planes. The patient is diagnosed with chronic pain syndrome. She has not been tried on a trial of intrathecal pain pump for the chronic axial and radicular lower limb pain and this is being requested as treatment. Prior utilization review dated 07/21/2014 states the request for Consult for intrathecal pain pump trial & consideration for permanent pump is denied as medical necessity has not been established.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Consult for intrathecal pain pump trial & consideration for permanent pump: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems, Page(s): 52-54. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations

**Decision rationale:** Per CA MTUS guidelines, Implantable drug-delivery systems (IDDSs) is recommended only as an end-stage treatment alternative for selected patients for specific conditions, after failure of at least 6 months of less invasive methods, and following a successful temporary trial. Implantable infusion pumps are considered medically necessary when used to deliver drugs for the treatment of Permanently implanted intrathecal 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 non-malignant (non-cancerous) pain with a duration of greater than 6 months and all of the following criteria are met:

1. Documentation, in the medical record, of the failure of 6 months of other conservative treatment modalities (pharmacologic, surgical, psychologic or physical), if appropriate and not contraindicated; and
2. Intractable pain secondary to a disease state with objective documentation of pathology in the medical record; and
3. Further surgical intervention or other treatment is not indicated or likely to be effective; and
4. Psychological evaluation has been obtained and evaluation states that the pain is not primarily psychologic in origin and that benefit would occur with implantation despite any psychiatric comorbidity; and
5. No contraindications to implantation exist such as sepsis or coagulopathy; and
6. A temporary trial of spinal (epidural or intrathecal) opiates has been successful prior to permanent implantation as defined by at least a 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 (intraspinous) infusion pumps is considered medically necessary only when criteria 1-5 above are met. In this case, documentation is limited and there is no evidence of the above criteria being met. Thus, the request is not considered medically necessary; non-certified.