

<b>Case Number:</b>	CM14-0030488		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	09/04/2008
<b>Decision Date:</b>	08/04/2014	<b>UR Denial Date:</b>	02/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2014

### 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 Orthopedic Surgery and is licensed to practice in Connecticut and 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 injured worker is a 57-year-old female who reported an injury on 09/04/2008 due to a repetitive trauma while performing normal job duties. The injured worker underwent surgical intervention in 2009 followed by multiple medications, an epidural steroid injection, and a morphine pump trial. The injured worker was evaluated on 02/25/2014. It was noted that the patient had significant low back pain that had not benefitted from lower levels of treatment including a morphine pain pump. It was noted that the injured worker had an allergic reaction to the morphine. It was noted that the patient intended to attempt water aerobics prior to insertion of a pain pump. It was also noted that the patient underwent a psychological evaluation that provided no contraindications to an implantable pain pump. Physical findings included decreased reflexes of the bilateral lower extremities with a positive straight leg raising test. The injured worker's diagnoses included discogenic degeneration of the lumbar spine, lumbar nerve root injury, epidural fibrosis, arachnoiditis, muscle spasms, discogenic syndrome of the lumbar spine, discogenic syndrome of the cervical spine, fatty liver, and insomnia. A request was made for a lumbar intrathecal pain pump implantation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Lumbar Intrathecal Pump Implant:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Implantable Drug-Delivery Systems (IDDS) Page(s): 52-53. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chronic, Implantable infusion Pump.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems (IDDSs) Page(s): 52.

**Decision rationale:** California Medical Treatment Utilization Schedule recommends an intrathecal pain pump implantation after all conservative treatments have been exhausted and the patient has been evaluated from a psychological standpoint for the appropriateness of this intervention. The clinical documentation submitted for review does indicate that the patient previously underwent a psychological evaluation. However, that evaluation was not provided for review. Additionally, it is noted within the documentation that the patient is continuing to attempt conservative treatment prior to this intervention. Therefore, the timing of this intervention may not be appropriate in this clinical situation. As such, the requested lumbar intrathecal pain pump implant is not medically necessary or appropriate.

**3 Day Inpatient Hospital Stay:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hospital Length of Stays (LOS).

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.