

Case Number:	CM14-0062551		
Date Assigned:	07/11/2014	Date of Injury:	05/30/1990
Decision Date:	08/28/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/05/2014

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 female who was reportedly injured on May 30, 1990. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated June 23, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated a well-developed, well-nourished, obese individual who was ambulatory with the use of a cane. Blood pressure was noted to 110/65 with a pulse rate of 101. This individual was 5'4, weighing 200 pounds. A decrease in lumbar spine range of motion was reported, and there was increased pain with flexion and extension. Strength was reported to be 5/5 on the right and 4/5 on the left. A decrease in cervical spine range of motion was also noted. Diagnostic imaging studies objectified were not reviewed. Previous treatment included lumbar laminectomy, postoperative pain management, spinal cord similar, implantable drug delivery systems, and other pain management interventions. A request had been made for replacement procedures and was not certified in the pre-authorization process on April 18, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Replacement IT (intrathecal) pump: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 52 of 127.

Decision rationale: As noted in the progress note, the injured employee declared that the low back pain was intolerable at a particularly high level and the pump did not ameliorate the symptomatology. There was no clinical indication relative to the efficacy of this pain control device. Therefore, it was not medically established that additional treatment did not work and would be clinically indicated. As such, given the relative failure of this device, replacing the device is not medically necessary. When noting the parameters outlined in the California Medical Treatment Utilization Schedule, the efficacy of this device has not been established and the criterion for a greater than 6 month's utilization of this device is not met, this is not medically necessary.

Replacement catheter: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 52 of 127.

Decision rationale: As noted in the progress note, the injured employee declared that the low back pain was intolerable, at a particularly high level and the pump did not ameliorate the symptomatology. There was no clinical indication relative to the efficacy of this pain control device. Therefore, it was not medically established that additional treatment did not work and would be clinically indicated. As such, given the relative failure of this device, replacing the device is not medically necessary. When noting the parameters outlined in the California Medical Treatment Utilization Schedule, and that the efficacy of this device has not been established and the criterion for a greater than 6 month's utilization of this device are not met, this is not medically necessary.

Pre-operative consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 52 of 127.

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

Pre-operative EKG (electrocardiogram): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 52 of 127.

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

Pre-operative chest x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 52 of 127.

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

Pre-operative laboratory tests, CBC, BMP, PT, PTT, SGOT, alk PTase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 52 of 127.

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