

Case Number:	CM14-0191520		
Date Assigned:	11/25/2014	Date of Injury:	12/14/2010
Decision Date:	01/30/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/17/2014

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 Family Practice and is licensed to practice in Florida. 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:

This is a 65-year-old female who suffered a work related injury on 12/15/2010. Diagnoses include primary osteoarthritis left leg, status post knee replacement (ono-industrial), chronic pain syndrome, lumbago status post-surgery, difficulty walking, and joint pain left lower extremity-left knee. A primary physician progress note dated 10/15/2014 documents the injured worker is doing better with pain control with current medications. She continues to have significant pain in her back. Pain is rated 3-4 out of 10. A trial of a spinal stimulator is recommended. Current medications and treatment afford about 50% decrease in symptoms but this is temporary. The injured worker has an antalgic gait with use of a walker with a forward flexion at the lumbar sacral spine. There is tenderness present on palpation to both knees, but mainly left knee. The lumbosacral spine has a surgical scar midline with bony and soft tissue protrusion in the upper lumbar and lower thoracic. Range of motion is decreased throughout the lumbosacral spine in all planes due to pain mainly with extension. There is mild to moderate tenderness throughout the lumbosacral spine and paraspinal with paralumbar muscle spasms. The injured worker is off work. Treatment request is for a pain pump implant. Utilization Review dated 11/06/2014 non-certifies the request for a pain pump implant citing California Medical Treatment Utilization Schedule (MTUS), Intrathecal Pain Pump-Implantable drug-delivery systems. Guidelines state it 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. In this case documentation fails to describe failure of 6 months of conservative treatment. Documentation further does not identify the claimant has completed an intrathecal pain pump trial as required by guidelines, and documentation does not include a psychological evaluation providing psychological clearance to undergo the procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Pump Implant: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Indications for Implantable Drug Delivery Systems Page(s): 53-54.

Decision rationale: MTUS guidelines provided the following criteria as indications for an implantable drug delivery system: "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 (intraspinal) infusion pumps is considered medically necessary only when criteria 1-5 above are met. "In regards to this patient's case, the above criteria have not been met. There is no documentation that this patient has had a trial of a spinal opiate. There is no documentation of a psychological evaluation. There is documentation that this patient has failed 6 months of conservative modalities. One of the progress notes provided stated that the patient's pain has been improving with her current medications. This request for a pain pump is not medically necessary.