

<b>Case Number:</b>	CM15-0133601		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	07/10/2003
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	06/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 (IW) is an 58 year old female who sustained an industrial injury on 07/10/2003. The initial mechanism and report of injury is not found in the records reviewed. The injured worker was diagnosed as having: Failed back surgery syndrome, (Lumbar); Lumbar degenerative disc disease; History of vertebral body compression fracture; Status post spinal cord stimulator replacement with current lead migration; Chronic pain syndrome; Myofascial pain syndrome; Thoracic spine pain. Treatment to date has included steroid injections, oral and topical medications. On 05/27/2015, the injured worker complains of severe pain in the junction of the lumbar and thoracic spine. Her spinal cord stimulator is not working properly. According to provider notes, a request for an intrathecal pump was denied by insurance with the request the worker have a spinal cord stimulator revision first to see if it would relieve her pain. Per the worker's report, her surgeon recommended an intrathecal pump for her pain. On exam, the range of motion of the thoracolumbar spine and the range of motion in the lower extremities were normal. The range of motion of the lower extremities knees and ankles were normal. Motor exam was normal in the lower extremities. Reflexes were also normal. Sensation was decreased in the right L4 and L5 dermatomal distribution to pinprick and light touch. There was tenderness to palpation over the sacral and coccygeal area with taunt band and trigger points referring the pain to both sides of the buttocks. There is tenderness to palpation over the right sacroiliac joint. The spinal cord stimulator battery is implanted in the lower back. The hips were non-tender and there was no appreciable flexion contracture of the hip. The knees and ankles had no appreciable tenderness on palpation. A right sacroiliac joint steroid injection was given 06/11/2015, but the

documentation does not give a worker response to the injection. The plan of treatment was for a right sacroiliac joint steroid injection trigger point injections (4) into the lumbar paraspinal muscles, for an increase in the fentanyl patch strength, and for an intrathecal pain pump. The worker received the intrathecal pump education, and passed the psychological evaluation for a pain pump. A request for authorization was made for the following: Single Shot Pump Trial, with Fluoroscopy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Single Shot Pump Trial, with Fluoroscopy: 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 Implantable Drug-Delivery Systems Page(s): 52.

**Decision rationale:** With regard to implantable drug-delivery systems, the MTUS CPMTG states: "Recommended only as an end-stage treatment alternative for selected patients for specific conditions indicated below, after failure of at least 6 months of less invasive methods, and following a successful temporary trial." Permanently implanted intrathecal (intraspinal) 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 (intraspinal) infusion pumps is considered medically necessary only when criteria 1-5 above are met. The documentation submitted for review indicates that the injured worker was given a right sacroiliac joint steroid injection on 6/11/15, but the documentation does not give a response to the injection. Furthermore, it appears that the plan of care included trigger point injections for lumbar paraspinal muscles which were approved per 6/15/15 utilization review. The injured worker has not failed conservative care for a period of six months. As criteria 1 above is not met, the request is not medically necessary.