MAXIMUS Federal Services

Case Number:	CM15-0137181		
Date Assigned:	07/29/2015	Date of Injury:	10/01/1991
Decision Date:	09/28/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	07/15/2015

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: Maryland, Texas, Virginia
Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 80 year old female, who sustained an industrial injury on October 1, 1991. Treatment to date has included cervical spine surgery, opioid medications, intrathecal pump trial, and home exercise program. A follow-up evaluation on January 8, 2015 revealed the injured worker reported pain in her low back. She reported neck pain and bilateral upper extremities pain. The pain in her low back was described as sharp, dull, aching, throbbing, pins and needles, stabbing, numbness, pressure, electrical shooting, burning, cramping, weakness and spasm. She rated her pain an 8 on a 10-point scale and noted that the low back pain is aggravated with activity, sitting, standing and walking. Her low back pain is relieved with cold, rest, lying down, quiet, sitting and medications. She reported a 40% improvement in her pain with her intrathecal pain pump. The use of her pain pump provided her better ability to perform activities of daily living. On physical examination the injured worker exhibited spasms of the right paracervical spine. She had diffuse tenderness to palpation of the mid parathoracic area and the bilateral paralumbar area. Her strength was decreased in the bilateral upper extremities and she had 2+ pedal edema bilaterally. The diagnoses associated with the request include thoracic strain, cervical spine stenosis, lumbar radiculopathy, lumbar-thoracic-cervical degenerative disc disease, failed neck surgery syndrome, and cervical radiculopathy. Her treatment plan included continued home exercise program, continued Norco and Kadian, Intrathecal pump refill and maintenance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pump refills and maintenance x 6 supplies (Refill kit for implantable infusion pump), Pump reprograms x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems (IDDSs) Page(s): 51-54.

Decision rationale: MTUS 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." MTUS further states "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." While the treating physician has met some of the above criteria, the treating physician has 6 refills and 6 reprograming which does not allow for continued close monitoring of ongoing pain suppression by 50-70%. The UR modified the request to allow for 1 refill which is reasonable. As such, the request Pump refills & maintenance x 6 supplies (Refill kit for implantable infusion pump), Pump reprograms X 6 is not medically necessary at this time.