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| Case Number: | CM15-0160669 | | |
| Date Assigned: | 08/27/2015 | Date of Injury: | 03/21/1990 |
| Decision Date: | 10/19/2015 | UR Denial Date: | 07/18/2015 |
| Priority: | Standard | Application Received: | 08/17/2015 |

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: Arizona

Certification(s)/Specialty: Surgery

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 51 year old male, who sustained an industrial injury on 3-21-1990. The records submitted for this review did not include documentation regarding the initial injury or a complete list of prior treatments to date. Diagnoses include multilevel cervical degenerative disc disease and stenosis, status post lumbar fusion, failed back surgery syndrome, lumbar radiculopathy, and status post intrathecal pump and spinal cord stimulator implant. Currently, he complained of ongoing headaches and pain in the neck, shoulder, elbow and wrist. The provider documented that the pain pump had moved and caused significant pain. The records indicated the injured worker was on blood thinners. On 7-9-15, the physical examination documented an ultrasound guided pump refill procedure was completed on this date. The plan of care included a request to authorize one pump replacement, fluoroscopy and sedation, and sedation-general anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 pump replacement/fluoroscopy and sedation/general anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem BCBS Implantable Infusion Pumps Policy Policy #: SURG.00068 Current Effective Date: 07/07/2015 https://www.anthem.com/medicalpolicies/policies/mp_pw_a053366.htm.

Decision rationale: Medically Necessary: Replacement of an implantable/intrathecal infusion pump (which may also involve upgrading to the most current technology) is considered medically necessary when the device is not functioning or when a built-in system in the pump provides notification of an impending failure. Not Medically Necessary: Replacement or upgrades of an implantable/intrathecal infusion pump is considered not medically necessary when requested for convenience or to upgrade to newer technology when the current components remain functional. In this case, this 51 year old male had his intrathecal infusion pump filled successfully 7/9/15. There were no alarms or notifications of impending failure. It was noted that the device had angled which was causing him some pain at the time of the pump fill. However, the pump was filled without documentation of complication or difficulty filling the device and the device is functioning and the current components remain functional at present. Therefore, the prior utilization review is upheld. The pump replacement/fluoroscopy and sedation/general anesthesia is not medically necessary.