

Case Number:	CM15-0181147		
Date Assigned:	09/22/2015	Date of Injury:	06/25/2012
Decision Date:	11/10/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/14/2015

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: Montana, Oregon, Idaho
 Certification(s)/Specialty: Orthopedic 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:

This injured worker is a 60 year old male, who sustained an industrial injury on 06-25-2012. The injured worker was diagnosed as having degenerative disc disease lumbar, low back syndrome, lumbar radiculopathy, post laminectomy syndrome, chronic pain syndrome and disorders of meninges. On medical records dated 08-24-2015 and 06-25-2015, the subjective complaints were noted as chronic low back and bilateral leg pain. Pain was noted at 7 out of 10. Objective findings were noted as no lumbar paraspinous muscle spasms, straight leg raise was negative, modest lumbar paraspinous muscle tenderness was noted and a mildly antalgic gait. Treatments to date included transforaminal epidural steroid injections, surgical intervention and medication. The injured worker was noted to be temporary totally disabled. Current medications were listed as Levothyroxine Sodium, Losartan Potassium-HCTZ, Zohydro ER and Norco. The Utilization Review (UR) was dated 09-04-2015. A Request for lumbar intrathecal pain pumps trial. The UR submitted for this medical review indicated that the request for lumbar intrathecal pain pump trial was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar intrathecal pain pump trial: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Implantable drug-delivery systems (IDDSs).

Decision rationale: CA MTUS/Chronic Pain Treatment Guidelines, Implantable drug-delivery systems (IDDSs), pages 52-54 recommend intrathecal pain pumps for non malignant pain with 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. Based upon the exam note from 8/24/15 there is no documentation of a psychological evaluation to determine if the pain is from a psychologic origin. The guidelines have not been met and therefore the determination is not medically necessary.