MAXIMUS Federal Services

Case Number:	CM15-0185720		
Date Assigned:	09/28/2015	Date of Injury:	02/22/1998
Decision Date:	11/10/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/22/2015

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 50-year-old female, with a reported date of injury of 02-22-1998. The diagnoses include left T2-3 and right T6-7 herniated disc, chronic pain syndrome, thoracic facet arthropathy, and history of compression fracture thoracic vertebra. Treatments and evaluation to date have included Baclofen, Voltaren gel, Percocet, Oxycontin, Ambien, Triazolam, Celebrex, Cymbalta, peripheral nerve stimulator, home exercise program, and physical therapy. The diagnostic studies to date have not been included in the medical records provided. The follow-up report 09-04-2015 indicates that the injured worker presented for follow-up and reported severe pain over the thoracic area. She also reported that when turned on the stimulator, she felt a sting and burn. It was noted that the stimulator helped significantly in the past, with controlling pain. The injured worker reported that her current pain medication helped to some extent, and also reported some side effects from the oral opioid pain medications. Her current pain level (08-07-2015 to 09-04-2015) was rated 8 out of 10 on a good day, and rated 10 out of 10 on a bad day (08-07-2015 to 09-04-2015). The injured worker's previous pain rating was 8 out of 10 on a good day, and 10 out of 10 on a bad day. The physical examination showed severe tenderness over the mid and lower thoracic area both midline and parathoracic area; limited thoracic spine range of motion due to pain; bilateral parathoracic tightness over the mid and lower thoracic area extending to the lumbar spine; negative straight leg raise test; moderate diffuse tenderness over the lower lumbar area; extension with pain to the lumbar area; and severe bilateral lumbar and thoracic spasm. The treating physician indicates that due to the severity of pain and failure of conservative treatment, including medication management, physical therapy, exercise

program, injection therapy, as well as peripheral nerve stimulator, an intrathecal pump trial was recommended. The injured worker's word status was noted as permanent and stationary. The treating physician requested an IT (intrathecal) pump trial with Dilaudid, anesthesia with x-ray, under fluoroscopic guidance times two. On 09-15-2015, Utilization Review (UR) non-certified the request for an IT pump trial with Dilaudid, anesthesia with x-ray, under fluoroscopic guidance times two.

IMR ISSUES, DECISIONS AND RATIONALES

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

IT pump trial with dilaudid, anesthesia with x-ray, under fluoroscopic guidance x2: 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: The following criteria for a temporary trial of a temporary trial of intrathecal (intraspinal) infusion pumps is considered medically necessary only when criteria 1-5 are met as stated below: 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. Although most of the above criteria have been met for an implantable intrathecal infusion pump, this patient does not have documentation in the medical record of a psychological evaluation stating that the pain is not psychologic in origin. Therefore, the prior utilization review is upheld and the IT pump trial with Dilaudid, anesthesia with x-ray, under fluoroscopic guidance times two is not medically necessary.