

Case Number:	CM15-0196368		
Date Assigned:	10/12/2015	Date of Injury:	09/17/2004
Decision Date:	11/30/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/06/2015

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: Texas, California

Certification(s)/Specialty: Family Practice

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 is a 63 year old female who sustained an industrial injury on 9-17-2004. A review of the medical records indicates that the injured worker is undergoing treatment for lumbago, thoracic or lumbosacral neuritis or radiculitis unspecified and lumbar post-laminectomy syndrome. According to the pain management re-evaluation dated 9-23-2015, the injured worker complained of post-operative low back pain and bilateral leg pain right greater than left. She rated her average pain 9 out of 10, her average mood 9 out of 10 and her functional level 8 out of 10 since the last visit. Per the treating physician (9-23-2015), the injured worker was on disability. The physical exam (9-23-2015) revealed "she continues to have ongoing severe low back pain with left greater than right leg pain to her foot consistent with her post-laminectomy syndrome." She was in a wheelchair. Her pain was noted to be worse in general without her full regimen. Treatment has included multiple lumbar surgeries, spinal cord stimulator (failed) and medications (Fentanyl patches, Nuvigil, Cymbalta, Zanaflex, Lyrica and Dilaudid). The treatment plan included continuing medications, continue home exercise program, follow up regarding bariatric medicine program and follow up for pre intra-thecal trial evaluation. Per the note dated 9/2/15, she was 6 weeks post removal of generator and spinal cord stimulator due to significant tenderness over SCS. The patient has had CT of the lumbar spine on 7/11/14 that revealed disc protrusions, foraminal and central canal narrowing, and degenerative changes. Patient had received lumbar ESI for this injury. The patient has a history of depression. The patient had received an unspecified number of PT visits for this injury. The patient has a history of DM and HTN. The patient has a history of spinal hardware infection. The patient underwent removal of lumbar hardware on 10/30/14 and lumbar fusion in 2007.

IMR ISSUES, DECISIONS AND RATIONALES

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

Proposed treatment consisting of [REDACTED] recommendation including pain pump: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Implantable Drug Delivery Systems (IDDSs).

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

Decision rationale: Proposed treatment consisting of [REDACTED] recommendation including pain pump. As per cited guidelines, "Implantable drug-delivery systems (IDDSs): 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. 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 (intraspinial) infusion pumps is considered medically necessary only when criteria 1-5 above are met." Evidence that all these indications for the Implantable drug-delivery systems were met was not specified in the records provided. Evidence of the failure of 6 months of other conservative treatment modalities (pharmacologic, surgical, psychologic or physical), was not specified in the records provided. A recent detailed psychological evaluation is not specified in the records provided. Per the note dated 9/2/15, she was 6 weeks post removal of generator and spinal cord stimulator due to significant tenderness over SCS. The patient has had history of spinal hardware infection. As per the cited guideline, one of the criteria for the use of an Implantable drug-delivery system / pain pump is, "No contraindications to implantation exist such as sepsis." The patient has had a history of DM and HTN and there is a possibility of infection. Response to prior conservative therapy is not specified in the records provided. Prior conservative therapy notes are not specified in the records provided. The medical necessity of the request for Proposed treatment consisting of [REDACTED] recommendation including pain pump is not fully established in this patient. Therefore, the request is not medically necessary.