

Case Number:	CM15-0021324		
Date Assigned:	02/10/2015	Date of Injury:	10/27/1997
Decision Date:	04/15/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	02/04/2015

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: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 71 year old female who sustained an industrial injury on 10/27/1997. Diagnoses include displacement of lumbar intervertebral disc without myelopathy, and post-laminectomy syndrome of the lumbar region. Treatment to date has included medications, surgery, injections, and intraspinal drug delivery system. A physician progress note dated 11/06/2014 documents the injured worker had her intraspinal drug delivery system refilled and reprogrammed under ultrasound guidance. She has transverse low back and left lower extremity pain. She is currently stable but low back pain is increasing. A physician progress note dated 11/19/2014 documents the battery life is rapidly approaching the end for the intraspinal drug delivery system pump. She is waiting for medical clearance for the surgery, due to her thrombocytopenia. Treatment requested is for Retrospective Pump Revision/Replacement. On 01/16/2015 Utilization Review non-certified the request for Retrospective Pump Revision/Replacement, and cited was California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Pump Revision/Replacement: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Implantable Drug-Delivery Systems.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Intrathecal delivery devices Page(s): 52.

Decision rationale: The MTUS and ODG are silent on specific criteria for replacement of IT drug delivery systems. The UR denial is not available in the records available for my review. However, the medical records supplied by the PTP document no ongoing substance abuse, and provide a clear and cogent rationale for use of IT opiate treatment, and documentation that this has been stable, effective, and safe. As this is a retrospective review, there is sufficient documentation to substantiate medical necessity as the battery in the device was near the end of its life and there was no contraindication to continuing IT pump therapy.