

Case Number:	CM15-0050229		
Date Assigned:	03/23/2015	Date of Injury:	10/08/1993
Decision Date:	05/12/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/17/2015

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: Oregon, California
 Certification(s)/Specialty: Neurological 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 71-year-old female who reported an injury on 10/08/1993. The mechanism of injury was unspecified. Her diagnoses included degenerative disc disease, thoracic-lumbar-lower limb radiculopathy, cervical-upper limb radiculopathy, and spondylolisthesis. Her past treatments include medications, surgery, and physical therapy. On 01/26/2015, the injured worker complained of low back pain rated 6/10 to 7/10, with an average of 5/10. The injured worker also complained of upper back pain in the parascapular region that radiated into the low back. Physical examination revealed limited range of motion in the lumbar spine. There was also tenderness to palpation of the lumbar paraspinal muscles. Motor strength and sensation were indicated to be normal. Ankle jerk reflexes were noted to be diminished, with no clonus noted. On 03/10/2015, the injured worker complained of chronic neck and back pain. She also reported that the neck pain has gotten worse. However, her left leg has increased sharpness, stabbing pain, and burning sensations, and she can hardly walk due to those causes. The injured worker rated her pain scale at 6/10 to 7/10. She denied significant side effects with current medications. She also reported 56% to 60% pain relief with the current treatment plan, and does not feel she will be able to function or live independently without the oral medications as prescribed. The injured worker was noted to live independently and manage her activities of daily living without assistance. The physical examination revealed improved cervical range of motion with minimal tenderness. Range of motion of the lumbar spine was noted to be decreased by 50% in all fields, with reported pain upon flexion, rotation, and lateral bending. The in office procedure included a sterile technique with a successful refill of the intrathecal pain with no

apparent complications. There was an absence of tenderness, erythema, or signs of infection. The pharmacological assessment and management noted the injured worker was counseled regarding the benefits of medications, side effects, risks, and potential problems. The injured worker was instructed to obtain refills from the main office only and that she is to use the medication as prescribed and directed. She may not obtain analgesic medications from other physicians, and a narcotics agreement was signed. The documentation indicated the injured worker showed no signs of medication abuse or diversion, and her previous random urine drug screens have been appropriate for morphine and Nucynta. A request was received for pump replacement/revision, quantity 1, pump catheter, quantity 1, pump analysis, quantity 1, with fluoroscopy, quantity 1. As the estimated life of the intrathecal pump is only indicated for 3 months. A Request for Authorization form was submitted on 02/03/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pump Replacement/Revision: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems (IDDSs) Page(s): 52.

Decision rationale: According to the California MTUS Guidelines, implantable fusion pumps are considered medically necessary when used to deliver drugs for the treatment of primary liver cancer, metastatic colorectal cancer, head/neck cancers, and severe or refractory spasticity, or cerebral/spinal cord origin in patients who are unresponsive to or cannot tolerate oral baclofen therapy. Furthermore, the guidelines indicate that permanent IDDS infusion pumps for the treatment of malignant pain when all of the following criteria are met to include: strong opioids or other analgesics that and adequate doses have failed to relieve pain or intolerable side effects; and life expectancies greater than 3 months. It is also used for the treatment of nonmalignant cancerous pain with a duration of greater than 6 months and all of the following criteria are met, to include documentation of the failure of 6 months or more of conservative treatments; intractable pain secondary to a disease state with objective documentation of palpology in the medical records; further surgical ventures or other treatment is not indicated or likely to be effective, psychological evaluation has been obtained and evaluation states that the pain is not primarily Psychologic in origin, no other contraindications to implantation exist, and a temporary trial of spinal opiates have been successful prior to permanent implantation. The injured worker was not noted to have had an implantable drug delivery system since at least 2008. The documentation also noted that the injured worker has improved function in regard to activities of daily living, and has managed to live independent and without assistance. The injured worker also reported 50% to 60% pain relief with the current medication regimen. However, the clinical documentation submitted for review indicated the injured worker has been utilizing oral medications along with topical analgesics for pain control. In addition, the injured worker has undergone other conservative measures to include an epidural steroid injection, which provided 80% to 90% relief of neck pain, and 100% relief of her headaches. Based on other forms of

conservative measures being utilized for pain relief and control, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary or appropriate at this time.

Pump Catheter: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pump Analysis: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Fluoroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.