

<b>Case Number:</b>	CM15-0089096		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	12/21/2001
<b>Decision Date:</b>	06/15/2015	<b>UR Denial Date:</b>	04/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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: North Carolina

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 71 year old female with a December 21, 2001 date of injury. A progress note dated March 18, 2015 documents subjective findings (chronic lower back pain radiating to the bilateral groin, right leg to foot, left leg down to below the knee; pain rated at a level of 9/10 without medications and 7-8/10 with medications), objective findings (standing with a forward flexion to her posture; severe tenderness across the lumbosacral area; positive bilateral straight leg raises; decreased range of motion of the lumbar spine; hypoesthesia on the bilateral feet, right is greater; dysesthesia on right leg to right foot, left leg to anterior and posterior knee), and current diagnoses (thoracic or lumbosacral neuritis or radiculitis; lumbar or lumbosacral degenerative disc disease; myalgia and myositis; chronic pain syndrome; lumbar facet joint arthropathy; lumbar spine scoliosis; sacroiliitis, not elsewhere classified; lumbar post laminectomy syndrome; myofascial pain). Treatments to date have included medications, spinal cord stimulator trial, back surgery, morphine spinal injection, heat, ice, and left shoulder surgery. The medical record identifies that medications were no longer helping control the pain. The treating physician documented a plan of care that included permanent implantation of a spinal pain pump.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One permanent spinal pain pump implant: 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 devices Page(s): 52-53.

**Decision rationale:** The California MTUS section on implantable drug delivery systems for non-malignant pain states the following criteria: 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 (intraspinous) infusion pumps is considered medically necessary only when criteria 1-5 above are met. The patient does not have a current psychological evaluation included in the clinical documentation for review and therefore all criteria for permanent placement have not been met and the request is not medically necessary.