

Case Number:	CM15-0089381		
Date Assigned:	05/13/2015	Date of Injury:	02/15/2005
Decision Date:	06/16/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 51-year-old male injured worker suffered an industrial injury on 02/15/2005. The diagnoses included back disorder, cervical syndrome, post laminectomy syndrome of the cervical region and lumbago. The injured worker had been treated with oral medication and intrathecal pain pump medications. On 3/27/2015, the treating provider reported pain on average 7/10 and pain level had increased since last visit. The treatment plan included Retrospective (DOS 3/27/2015) 1 Pain Pump Refill and Reprogramming.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (DOS 3/27/2015) 1 Pain Pump Refill and Reprogramming: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems (IDDSs) Page(s): 51-54.

Decision rationale: MTUS states "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." MTUS further states "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." The provided medical documentation from the progress report dated 02/13/15 indicate the patient's pain level has increased since last visit with a 7 day average VAS score of 9/10. The patient continues to be prescribed opiate medications in addition to the use of the pain pump with no overall functional improvement. As such, the request for Retrospective (DOS 3/27/2015) 1 Pain Pump Refill and Reprogramming is not medically necessary at this time.