

Case Number:	CM14-0148600		
Date Assigned:	09/18/2014	Date of Injury:	08/31/2009
Decision Date:	10/16/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/12/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Injured worker is a female with date of injury 8/31/2009. Per pain management follow up note dated 7/30/2014, the injured worker complains of mid back, low back, and right lower extremity pain. Her pain is relatively unchanged since her last visit. Her pain today is about 4-5/10. She denies any new areas of pain, numbness, tingling, weakness, nor bowel or bladder dysfunction. She notes increased activities of daily living with her current regimen. She is taking Norco 10/325 mg maximum 7-8 per day, methadone 10 mg 1-2 tabs every 12 hours and Celebrex 200 mg daily. She continues to have constipation side effects. She request to reduce her methadone from maximum 4 per day to maximum 3 per day. On examination of lower back, lumbar range of motion flexion and extension has mild to moderate limitation with mild pain and spasms. There is a well healed scar from SCS implant. There is mild paravertebral spasm noted. Gait reveals a limp due to right lower extremity pain. There is generalized lower extremity weakness noted. Right ankle range of motion is limited with flexion, dorsiflexion, inversion, and eversion due to pain. There is allodynia and mild edema noted. Diagnoses include 1) lumbar/sacral radiculopathy 2) post laminectomy syndrome, lumbar 3) spondylosis, lumbosacral 4) reflex sympathetic dystrophy of lower limb 5) thoracic or lumbosacral neuritis or radiculitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

IT Pump Trial with Fentanyl: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems (IDDSs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable Drug-Delivery System (IDDSs) section Page(s): 52-54.

Decision rationale: The MTUS Guidelines recommend the use of an implantable drug delivery system only as an end-stage treatment alternative for selected patients for specific conditions, after failure of at least 6 months of less invasive methods, and following a successful temporary trial. IDDSs may be appropriate in selected cases of chronic, severe low back pain or failed back syndrome. This treatment should only be used relatively late in the treatment continuum, when there is little hope for effective management of chronic intractable pain from other therapies. For most patients, it should be used as part of a program to facilitate restoration of function and return to activity, and not just for pain reduction. The criteria for use for non-malignant pain with duration of greater 6 months includes: 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 records; 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 psychological 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 (intraspinal) infusion pumps is considered medically necessary only when criteria 1-5 above are met. The requesting physician explains that this request is for reflex sympathetic dystrophy of lower limb, persistent low back pain, and lower extremity pain. With the approval of the IT pump trial, the provider recommends removal of the spinal cord stimulator while the IT pump is being installed. The claims administrator reports that there is no documentation of a recent psychological evaluation to indicate that the pain is not psychological in origin. Without this, medical necessity for the IT pump trial with Fentanyl cannot be determined. Psychological evaluation dated 9/7/2012 was provided for review. This report notes that the injured worker is a suitable candidate from a psychological point of view to have a spinal cord stimulator trial. There are no psychological contraindications. There are no indications of cognitive problems that would impact her capacity to understand and utilize a spinal cord stimulator. The request for IT Pump Trial with Fentanyl is determined to be medically necessary.