

<b>Case Number:</b>	CM14-0216666		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	03/31/2000
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2014

### 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. 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  
 Certification(s)/Specialty: Orthopedic 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 55 year old male with a date of injury of March 31, 2000. Results of the injury have included neck and low back. Diagnosis included arachnoiditis. Treatment has included narcotics, surgery, due to severe degeneration, ambien, clonazepam, cymbalta, prilosec, zanaflex, and norco. Medical imaging was not provided. Progress report dated June 12, 2014, 2014 showed the injured workers pain was well controlled with pump medications. There was no infection. Physical examination noted no evidence of infection. Disability status was noted as permanent and stationary. The plan was to refill the pump and follow up in 3-5 months depending on pump size. Utilization review form dated December 15, 2014 non certified 1 intrathecal pain pump refill, outpatient, for arachnoiditis Lumbar spine due to noncompliance with the Commission/URAC state and federal guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Intrathecal pain pump refill, outpatient, for arachnoiditis lumbar spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Implantable drug delivery systems Page(s): 52-54.

**Decision rationale:** CA MTUS/Chronic Pain Treatment Guidelines, Implantable drug-delivery systems (IDDSs), pages 52-54 recommend intrathecal pain pumps for non malignant pain with 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 (intra-spinal) infusion pumps is considered medically necessary only when criteria 1-5 above are met. Based upon the exam note from 6/12/14 there is insufficient evidence of improvement or reduction in medication to warrant a refill for arachnoiditis. Therefore the determination is for non-certification.