

<b>Case Number:</b>	CM14-0217269		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	01/05/1991
<b>Decision Date:</b>	03/04/2015	<b>UR Denial Date:</b>	12/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/29/2014

### 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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

This employee is a 76 year old female with date of injury of 1/5/1991. A review of the medical records indicate that the patient is undergoing treatment for lumbosacral neuritis and failed back syndrome. Subjective complaints include continued low back pain rated at 9/10 before pump broke and now 10/10. Objective findings include limited range of motion of the lumbar spine with tenderness to palpation of the paravertebrals; pump flips over due to sutures being broken. Treatment has included Norco orally and Morphine, Baclofen and Bupivaine via pump . The utilization review dated 12/16/2014 non-certified intrathecal pump revision.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Intrathecal Pump Revision:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines IDDSs Page(s): 52-53.

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

**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 (intraspinous) infusion pumps is considered medically necessary only when criteria 1-5 above are met.' The employee has had the pump for several years, but recently it has gotten loose and flips over, making it malfunction. It is unclear from the medical documentation that it needs to be replaced or just modified. Furthermore, there is no documentation showing a 50-70% reduction in pain or any functional improvement. Therefore, the request for an intrathecal pump revision is not medically necessary.