

Case Number:	CM15-0008356		
Date Assigned:	01/23/2015	Date of Injury:	07/03/1995
Decision Date:	03/13/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	01/14/2015

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 & Gen Prev Med

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 66 year old female who sustained an industrial related injury on 7/3/85. The injured worker had complaints of low back pain. The injured worker had a history of right low back and hip pain in the setting of failed back surgery syndrome and lumbar degenerative disc disease with radiculopathy. The injured worker has had 5 back surgeries the most recent in April 2014. A pain pump test had recently been done and the injured worker stated it had provided pain relief. Other treatment included ice, heat, exercise, and stretching. Prescriptions included MS Contin, Oxycodone, Prilosec, and Soma. Diagnoses included lumbar sprain, pain in limb, lumbar post-laminectomy syndrome, lumbar radiculopathy, and degeneration of lumbar or lumbosacral intervertebral disc. The treating physician requested authorization for a referral for spinal pain pump. On 12/11/14 the request was non-certified. The utilization review physician cited the Medical Treatment Utilization Schedule guidelines and noted the provided documentation did not include objective documentation of pathology or indicate that surgical intervention was not indicated. No psychological evaluation or temporary trial results were provided. Therefore the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral for Spinal Pain Pump: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems (IDDS) Page(s): 53-55.

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."While the treating physician has met some of the above criteria, the treating physician has not met all six criteria for an Implantable drug-delivery system (IDDSs), specifically details of trial of IDDS or psychological evaluation. As such, the request for IT pump exchange to 20 (twenty) cc pump/medications is not medically necessary at this time.