

<b>Case Number:</b>	CM15-0126778		
<b>Date Assigned:</b>	07/13/2015	<b>Date of Injury:</b>	05/12/2014
<b>Decision Date:</b>	08/07/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2015

### 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: California, Indiana, New York  
Certification(s)/Specialty: Internal 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 injured worker is a 59 year old male who sustained an industrial injury on 5/12/14. Diagnoses are cervical disc herniation without myelopathy, lumbar disc displacement without myelopathy, partial tear of rotator cuff tendon of bilateral shoulders, carpal sprain/strain of bilateral wrists, tear of medial meniscus of bilateral knees, sleep disorder, and anxiety. In a progress report dated 3/16/15, a treating physician notes complaint of constant severe cervical spine, left shoulder, lumbar spine, and bilateral knee pain and moderate to severe right shoulder pain. In a comprehensive orthopedic consultation dated 3/9/15, the treating physician notes he complains of bilateral knee pain which is constant and rated as 8/10 and radiates down the leg. Range of motion of the knees on extension is; right 12 degrees and left 1 degree, flexion on the right is 10 degrees and on the left is 14 degrees. Grind test is positive over both knees. Diagnosis is bilateral knee internal derangement with torn menisci. He is recommended for partial medial meniscectomy, chondroplasty patella with possible synovectomy. Previous treatment includes transcutaneous electrical nerve stimulation unit, physical therapy, and pain medications. Work status is noted as released to work with restrictions until 5/16/15. The requested treatment is 1 purchase of a pain pump.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 purchase of pain pump:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th edition (web), 2015, Post-op ambulatory infusion pumps (local anesthetic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Implantable drug delivery systems.

**Decision rationale:** Pursuant to the Official Disability Guidelines, one purchase of pain pump is not medically necessary. Pain pumps are used for treatment of nonmalignant (noncancerous) pain with a duration of greater than six months and all of the following criteria are met and documented by treating providers in the medical record. These include non-opiate oral medication regimens have been tried and failed to relieve pain and improve function; at least six months of other conservative treatment modalities including injection, surgical, psychological or physical) have been ineffective in relieving pain and improving function; intractable pain secondary to a disease state with objective documentation of pathology; further surgical intervention or other treatment is not indicated are likely to be effective; independent psychological evaluation has been obtained and the evaluation states pain is not psychological origin, the patient has realistic expectations and that benefit would occur with implantation despite any psychiatric comorbidity and no contraindication exists; there has been documented improvement in pain and function in response to oral opiate medications; a temporary trial of spinal (epidural or intrathecal) opiates has been successful prior to permanent implantation as defined by 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 infusion pumps is considered medically necessary only when the criteria enumerated above are met. In this case, the injured workers working diagnosis is internal arrangement with torn meniscus bilateral knees. The date of injury is May 12, 2014. Request for authorization is dated June 17, 2015. The most recent progress note in the medical record is dated March 9, 2015. There is no contemporaneous clinical documentation on or about the date of request for authorization (June 17, 2015). Subjectively, the injured worker has bilateral knee pain 8/10. The injured worker received acupuncture, medications, TENS and PT. The requesting provider order crutches and a knee brace in addition to postoperative physical therapy, medications, narcotics initially that anti-inflammatories, a cold therapy unit and postoperative bracing. There is no clinical discussion, indication or rationale for a pain pump, rental or purchase. Based on clinical information in the medical record, the peer-reviewed evidence-based guidelines and clinical documentation with a clinical indication and rationale for a pain pump, one purchase of pain pump is not medically necessary.