

Case Number:	CM15-0179907		
Date Assigned:	09/21/2015	Date of Injury:	07/07/2000
Decision Date:	10/26/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/14/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 50-year-old female, who sustained an industrial injury on 7-7-2000. The medical records submitted for this review did not include documentation regarding the initial injury or prior treatments to date. Diagnoses include chronic low back pain, failed back syndrome, and radiculopathy. Currently, she complained of increased pain in the low back with radiation to bilateral shoulder areas. Current medications included Neurontin, Robaxin, Cymbalta, gabapentin, Lunesta, methadone, Soma and Fentanyl via a pain pump. The intrathecal infusion pump noted to provide 50-75% pain relief. On 8-7-15, the physical examination documented decreased lumbar range of motion with decreased sensation to bilateral lower extremities. The intrathecal pain pump was refilled and reprogrammed with an increased pump rate on this date. The plan of care included intrathecal pump replacement. The appeal requested authorization for the replacement intrathecal pump. The Utilization Review dated 9-4-15, indicating the available records did not support that it was medically necessary citing the California MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Replacement Intrathecal pump: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Implantable drug-delivery systems (IDDSs).

Decision rationale: The claimant has a remote history of a work injury in July 2000 and is being treated for chronic pain including a diagnosis of failed back surgery syndrome. Treatments included an intrathecal drug delivery system with reported 50-75% pain relief. When seen in June 2015, the pump was refilled and reprogrammed. The estimated replacement interval was 3 months. In this case, the claimant's intrathecal drug delivery system is nearly at the end of its expected service life and continues to provide benefit. It needs to be replaced before it fails. Therefore, the request is medically necessary.