MAXIMUS Federal Services

Case Number:	CM15-0021884		
Date Assigned:	02/11/2015	Date of Injury:	01/10/2002
Decision Date:	06/03/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/05/2015

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, Washington
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 42 year old female, who sustained an industrial injury on 11/10/2002. Diagnoses include lumbar disc degeneration, lumbar radiculopathy, joint derangement, depression, malaise and fatigue and lumbar stenosis. Treatments to date include prior insertion and removal of an intrathecal pump, physical therapy and medication management. A progress note from the treating provider dated 12/24/2014 indicates the injured worker reported low back pain that radiated to the right lower extremity. The injured worker was utilizing naproxen, Prilosec, Tizanidine, Dilaudid, MS Contin, Zofran, and Alprazolam. Upon examination of the lumbar spine, there was limited range of motion, moderate tight band and muscle spasm, minimal hypertonicity, moderate tenderness along the bilateral lumbar region, positive straight leg raising bilaterally, moderate tenderness of the bilateral SI joints, positive Patrick's test, positive Yeoman's and Gaenslen's tests, swelling along the entire right thigh, restricted right knee range of motion, tenderness over the medial and lateral joint line, patellar tenderness, positive anterior drawer sign, positive patellar apprehension, positive patellar tilt, positive patellar grind test, positive Apley's compression test, diminished motor strength, and increased sensation with dysesthesia, hyperpathia, and paresthesia along the bilateral L4-S1 nerve root distributions. Treatment recommendations included continuation of the current medication regimen as well as a referral to an orthopedic surgeon. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intrathecal pump system implant: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (IDDSs) implantable drug-delivery systems Page(s): 52 and 53.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 53-55, and 101.

Decision rationale: The California MTUS Guidelines recommend pre intrathecal drug delivery system psychological evaluation. Intrathecal drug delivery systems are recommended as indicated. There should be documentation of a failure of 6 months of conservative treatment and intractable pain secondary to a disease state with objective documentation of pathology. In this case, the injured worker reports ongoing low back pain radiating into the right lower extremity. The injured worker underwent a prior implantation of an intrathecal pump on 05/03/2012 with removal on 06/06/2012. The injured worker's response to the prior intrathecal pump implantation as well as the reason for explanation was not clearly identified in the documentation provided. Given the above, the request is not medically necessary at this time.

Pre-operative labs: comprehensive metabolic panel, CBC, Hematocrit, hemoglobin: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Pre-operative testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 53-55, and 101.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the associated request is not medically necessary.

Pre-operative: EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 53-55, and 101.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the associated request is not medically necessary.

Pre-operative: Chest x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Pre-operative testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 53-55, and 101.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the associated request is not medically necessary.

Nasal PCR test for MRSA: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.labtestsonline.org/understanding/features/methods/start/5.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 53-55, and 101.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the associated request is not medically necessary.