

<b>Case Number:</b>	CM15-0063172		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	10/17/2002
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, 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 66 year old female, who sustained an industrial injury on October 17, 2002. She reported injuries to her right leg and right arm following a fall. Treatment to date has included imaging of the cervical spine, lumbar spine and bilateral shoulders, TENS unit, orthotics and assistive devices, cervical fusion, bilateral shoulder surgeries, total knee replacement, lumbar fusion and medications. Currently, the injured worker complains of neck pain, bilateral hip pain, bilateral shoulder pain, left knee pain, low back pain, headaches and recurrent falls related to low back pain. Her treatment plan included lumbar spine surgery, TENS unit, medications, shoe lift, home healthcare assistant and an opioid pump.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Intrathecal opioid trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Implantable Drug-Delivery Systems Page(s): 52.

**Decision rationale:** With regard to implantable drug-delivery systems, the MTUS Chronic Pain Medical Treatment Guidelines 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." Permanently implanted intrathecal (intraspinal) infusion pumps for the administration of opiates or non-opiate analgesics, in the treatment of chronic intractable pain, are considered medically necessary when: 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, psychological 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 psychological 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 (intraspinal) infusion pumps is considered medically necessary only when criteria 1-5 above are met. Per progress report dated 3/24/15, it was noted that the injured worker had a history of lumbar spine discomfort that she described as 9/10; cervical spine discomfort that she described as 9/10; right shoulder discomfort 9/10; bilateral hip discomfort 10/10 right greater than left. Pain decreases to about 6/10 with medications, and they allow her to do her activities of daily living along with household chores, and grocery shopping. As the injured worker is not refractory to less invasive conservative treatment, the medical necessity of intrathecal opioids cannot be affirmed. Therefore, this request is not medically necessary.