MAXIMUS Federal Services

Case Number:	CM15-0096379		
Date Assigned:	05/26/2015	Date of Injury:	03/15/2012
Decision Date:	06/26/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	05/19/2015

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
Certification(s)/Specialty: Family Practice

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 54-year-old female, who sustained an industrial injury on 3/15/12. She reported numbness and pain in both hands. The injured worker was diagnosed as having a history of bilateral carpal tunnel release with persistent symptoms, left shoulder rotator cuff syndrome, status post bilateral carpal tunnel release, and status post left cubital tunnel release with increase post-operative pain. Treatment to date has included C5-7 discectomy, bilateral decompression and foraminotomy, and fusion on 10/27/11. Other treatment included a left elbow Cortisone injection, a thumb injection, physical therapy, left cubital and left carpal tunnel release in February 2011, and right carpal tunnel release in August 2014. Currently, the injured worker complains of left shoulder and bilateral hand pain. The treating physician requested authorization for the purchase of a pain pump and a 30-day rental of an interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

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), Shoulder, Post-operative pain pump.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Chronic Pain Section: Implantable Drug-Delivery Systems/Pain Pumps.

Decision rationale: The Official Disability Guidelines comment on the use of Pain Pumps, also known as Implantable Drug-Delivery Systems, for the treatment of chronic pain. These devices are 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. There is insufficient evidence to recommend the use of implantable drug-delivery systems (IDDS) for the treatment of chronic pain. There are no high quality studies on this topic that document that this therapy is safe and effective. Further, significant complications and adverse events have been documented and the data identifies a substantial risk to patients. Permanently implanted intrathecal (intraspinal) infusion pumps for the administration of opioids or non-opioid analgesics, in the treatment of chronic intractable pain, are considered medically necessary when: Used for the treatment of malignant (cancerous) pain and all of the following criteria are met: (1) Strong opioids or other analgesics in adequate doses, with fixed schedule (not PRN) dosing, have failed to relieve pain or intolerable side effects to systemic opioids or other analgesics have developed; and (2) Life expectancy is greater than 3 months (less invasive techniques such as external infusion pumps provide comparable pain relief in the short term and are consistent with standard of care); and (3) Tumor encroachment on the thecal sac has been ruled out by appropriate testing; and (4) No contraindications to implantation exist such as sepsis or coagulopathy; and (5) A temporary trial of spinal (epidural or intrathecal) opioids has been successful prior to permanent implantation as defined by a 50% reduction in pain. A temporary trial of intrathecal (intraspinal) infusion pumps is considered medically necessary only when criteria 1-4 above are met. 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 and documented by treating providers in the medical record: (1) Non-opioid oral medication regimens have been tried and have failed to relieve pain and improve function (see functional improvement); and (2) At least 6 months of other conservative treatment modalities (injection, surgical, psychologic or physical), have been ineffective in relieving pain and improving function; and (3) Intractable pain secondary to a disease state with objective documentation of pathology in the medical record (per symptoms, physicial examination and diagnostic testing); and (4) Further surgical intervention or other treatment is not indicated or likely to be effective; and (5) Independent psychological evaluation has been obtained and evaluation states that the pain is not primarily psychologic in origin, the patient has realistic expectations and that benefit would occur with implantation despite any psychiatric comorbidity; and (6) No contraindications to implantation exist such as sepsis, spinal infection, anticoagulation or coagulopathy; and (7) There has been documented improvement in pain and function in response to oral opioid medications but intolerable adverse effects preclude their continued use; and (8) 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 1-7 above are met.In this case, there is insufficient evidence that the patient has met the above-cited criteria for the use of a pain pump

as part of the treatment strategy of her chronic pain. In order to be recommended, there would have to have been a therapeutic trial in which objective functional outcomes were assessed. Further, the patient would have to meet the above-cited criteria. For these reasons, the purchase of a pain pump is not medically necessary.

30 day rental of IF unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: The MTUS/Chronic Pain Medical Treatment guidelines comment on the use of an Interferential (IF) Unit. These guidelines state that IF is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. In addition, although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. While not recommended as an isolated intervention, patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. In this case, the records provide insufficient documentation that the patient meets these above cited MTUS criteria to warrant the use of a IF Unit for a 30 day rental. This device is not medically necessary.