

Case Number:	CM15-0097929		
Date Assigned:	05/29/2015	Date of Injury:	04/15/2004
Decision Date:	06/26/2015	UR Denial Date:	05/07/2015
Priority:	Standard	Application Received:	05/20/2015

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: New York
 Certification(s)/Specialty: Neurological Surgery

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 57 year old male, who sustained an industrial injury on 4/15/04. The injured worker was diagnosed as having intractable posttraumatic headaches, cervical strain with bilateral cervical radiculitis, overuse syndrome of upper extremities, lumbar radiculopathy, depression due to chronic pain and T12 compression fracture. Treatment to date has included cervical fusion, bilateral carpal tunnel release, lumbar surgery, radiofrequency ablation, physical therapy, oral medications including opioids, back brace, abdominal binder and home exercise program. Lumbar (MRI) magnetic resonance imaging performed on 1/12/15 revealed postoperative changes between L3 and S1, degenerative changes between L4-5 and old compression deformity at T12. Currently, the injured worker complains of neck pain rated 9/10 and low back pain rated 10/10. He is considered permanent and stationary. Physical exam noted well healed surgical scar at T12-L1 with decreased range of motion and tenderness and spasm of cervical spine paracervical muscles with decreased range of motion. A request for authorization was submitted for an intrathecal pump, home health care, follow up appointment and use of back brace and abdominal binder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain pump implantation: Upheld

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

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

Decision rationale: The ODG guidelines do recommend IDDSs only as an end-stage treatment. Documentation does not contain evidence this is the case. The guidelines do recommend IDDSs to deliver drugs for the treatment of primary liver cancer and metastatic colorectal cancer. The patient does not have these. The documentation does not furnish evidence the patient meets the criteria for implantation to treat chronic pain. The requested treatment: Pain pump implantation is NOT medically necessary and appropriate.

Durable medical equipment (DME) back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter-Lumbar supports.

Decision rationale: The ODG guidelines do not recommend lumbar supports for prevention. The guidelines note there is strong and consistent evidence that lumbar supports are not effective in preventing neck and back pain. The requested treatment: Durable medical equipment (DME) back brace is NOT medically necessary and appropriate.

Durable medical equipment (DME) abdominal binder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter-lumbar supports.

Decision rationale: The ODG guidelines do not recommend lumbar supports for prevention. The guidelines note there is strong and consistent evidence that lumbar supports are not effective in preventing neck and back pain. The documentation does not provide evidence that the abdominal binder is effective in treating the patient's pain either. The requested treatment: Durable medical equipment (DME) back brace is NOT medically necessary and appropriate.

Home health care, unspecified duration: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter- Home Health services.

Decision rationale: The ODG guidelines do recommend home health services on a short-term basis following major surgical procedures. Documentation shows this is not the case. The guidelines recommend home health services when there are objective deficits in function and the medical condition necessitates the services. Documentation does not provide this evidence. The requested treatment: Home health care, unspecified duration is NOT medically necessary and appropriate.