



IRO REPORT

DATE OF REVIEW: 4/9/07

MDR TRACKING #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness of the previously denied request for placement of a thoracic intrathecal narcotic pump, 62311; Ambul infusion pump electric/battery, E0781. Fluroscopic examination, 76000; prescription drug, oral, J7150.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Pain management

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

The previously denied placement of a thoracic intrathecal narcotic pump.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Fax Cover Sheet/Comments dated 3/26/07, 3/20/07, 3/14/07, 3/13/07, 2/19/07, 3/2/07, 7 pages.
- Notice of Assignment of Independent Review Organization dated 3/26/07, 2 pages.

- **Pre- Authorization Request (unspecified date), 1 page.**
- **Form for Requesting a Review by an Independent Review Organization (unspecified date), 1 page.**
- **Name of Party Requesting Independent Review Organization (unspecified date), 1 page.**
- **Additional Physicians or Health Care Providers/Attachment (unspecified date), 3 pages**
- **Utilization Review Agent (unspecified date), 2 pages.**
- **Denial Information dated (unspecified date), 1 page.**
- **Request for a Review by an Independent Review Organization dated 3/13/07, 3 pages.**
- **Correspondence dated 3/20/07, 3/7/07, 2/22/07, 7 pages.**
- **Position Statement dated 3/26/07, 2 pages.**
- **SOAP Note dated 2/19/07, 2 pages.**
- **Thoracic Spine MRI dated 2/1/07, 1 page.**
- **Peer Review Reports dated 2/22/07, (unspecified date), 2 pages.**
- **Medical Necessity Letter dated 2/26/07, 2 pages.**
- **Utilization Review Physician Advisor Report dated 3/7/07, 2 pages.**
- **Psychological Assessment dated 4/19/06, 4 pages.**

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Age:

Gender: Female

Date of Injury:

Mechanism of Injury: Lifting type.

Diagnosis: Thoracic spondylosis; thoracic spine pain; chronic reactive depression.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The review of the information submitted indicated that this patient had a subtle work injury involving the lumbar spine. The patient was found to have thoracic spondylosis based upon a thoracic MRI performed on 2/1/07. The patient complained of mid back pain, which was rated on a visual analog scale (VAS) as 4/10 to 5/10. The patient reported that the pain was constant and that it worsened as the day progressed. Aggravating factors included changes in the weather. Current medication management consisted of Zanaflex 4 mg two p.o. q.h.s. and Lexapro 10 mg one p.o. q.d. Objective findings pertaining to the thoracic spine was not documented. According to the requesting provider's "To Whom it May Concern" letter, submitted on 2/26/07, this patient has had intractable pain for over two years. Interventional pain management procedures tried include RFTC thoracic median branch nerves, thoracic epidural steroid injections, and a spinal cord stimulator trial (4/19/06) all resulting in an unsustained pain only. It was the provider's opinion that in light of multiple failed conservative treatments,

he believed that this patient was a candidate for an intrathecal narcotic pump trial. Of note, the patient was treated by Dr. PA-C (psychologist) for a thoracic intrathecal implant pump placement. According to the peer reviews previously performed, it appears that, in this case, this patient has not had a full oral narcotic trial indicating failures or side effects of multiple medications prior to progressing to an intrathecal narcotic pump trial. In addition, the patient has not undergone a recent chronic pain management program, which would be in order to provide this claimant with functional restoration so that she could return to gainful Suitable employment. Since the patient was suffering from mid back pain and showed true features of a reactive depression, it is the opinion of this reviewer that a thoracic narcotic intrathecal pump trial at this time is not medically necessary and will be denied. It appears from the documentation that not all appropriate chronic pain agonists have been attempted. It is the opinion of this reviewer that spinal administration of opioids should be certified for those patients who develop intractable side effects to pump treatment with oral therapies.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE (Chapter 12).
- AHCPR – AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES.
- DWC – DIVISION OF WORKERS’ COMPENSATION POLICIES OR GUIDELINES.
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN.
- INTERQUAL CRITERIA.
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS.
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES.
- MILLIMAN CARE GUIDELINES.
- ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES. ODG Volume II- Pain pumps.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHRIOPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.

- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).

Interventional Pain Management, Second Edition, Edited by Dr. Steven D. Waldman, Chapter 38 and Chapter 63.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.