



## REVIEWER'S REPORT

**DATE OF REVIEW:** 08/21/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Pain pump.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.O. with Physical Medicine and Rehabilitation, and Pain Management board certifications.

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This is a male who has a history of a back injury at work on xx/xx/xx while bending over. He had a prior history of a laminectomy at the L4/L5 level in 1989. He has had numerous diagnostic tests as recorded above. He has had various therapies applied, including injections, spinal cord stimulator, and has been treated with oral medications. Notes from his treating physicians indicate the spinal cord stimulator is covering the pain areas it was intended to cover, and where it was not covering the pain, he was being supplemented with oral medications and appeared to be stationary. There did not appear to be any change in his clinical presentation or symptomatology documented in the records reviewed in the recent past while using the stimulator and the oral medications.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

It is my opinion that his current status appears to be controlled with the spinal cord stimulator and oral medications with no significant alteration in his clinical presentation while with the medications and spinal cord stimulator, both of which appear to be working, according to the records. With this in mind, there does not appear to be sufficient evidence to warrant the addition of intrathecal pump to the above two strategies, that being the spinal cord stimulator and the oral medications, as they do appear to be controlling his symptomatology, although certainly not eliminating it.

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

*(Check any of the following that were used in the course of your review.)*

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)