

Parker Healthcare Management Organization, Inc.

4030 N. Beltline Rd Irving, TX 75038
972.906.0603 972.255.9712 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 6, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed permanent intrathecal Morphine pump (62350, 62362, 62368, 77003)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

- Upheld (Agree)
- XX Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.83	62350, 62362, 62368, 77003		Prosp	1					Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-17 pages

Respondent records- a total of 23 pages of records received to include but not limited to: letter, 1.23.08, 12.14.07(ODG criteria listed), 1.4.08 (ODG criteria listed); records, Dr. 7.11.07-11.30.07; Lumbar Myelogram w/CT 11.16.06

Requestor records- a total of 16 pages of records received to include but not limited to: records, Dr., 7.11.07-12.20.07; Lumbar Myelogram w/CT 11.16.06;

PATIENT CLINICAL HISTORY [SUMMARY]:

This individual sustained a severe work-related injury resulting in spinal cord inverse fractured L3. The patient has had multiple spinal decompressive surgeries and post laminectomy syndrome and intractable pain. He had received a previous spinal cord stimulator which has now failed to function. He is a candidate for an intrathecal pump. He has had a psychiatric evaluation that shows he is an appropriate candidate.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

The disputed procedure was previously denied because of failure to document outcome with trial. I have reviewed records today showing the patient at 80-90% relief with the trial and this is the best that he has felt in many years. Therefore, he meets all 6 criteria of the ODG guidelines.

Those criteria include:

1. Documentation of medical records, and a failure of 6 months of conservative care.
2. Intractable pain in secondary disease state with objective documentation of pathology in the medical record. He has a burst fracture and postoperative arachnoiditis.
3. Further surgical intervention and other treatment is not indicated or likely defective.
4. Psychological evaluation has been obtained. However, the patient states that the pain is not primarily psychologic in nature.
5. No contraindications for implantation exists such as sepsis or coagulopathy.
6. A temporary trial of spinal (epidural or intrathecal) opiates has been successful prior to program implant with at least 50-70% reduction in pain.

CONCLUSION: The patient meets ODG guidelines and his medical history is consistent with a work related problem of intractable pain. Therefore, per the records medical necessity has been established.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES