Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 11/10/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of an intrathecal opioid trial, placement (62350), Daily Management (01996), Removal (62355), Fluoroscopy (77003), and inpatient stay x 1 day.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. Secondly, this physician performs this service in his private practice.

REVIEW OUTCOME

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

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of an intrathecal opioid trial, placement (62350), Daily Management (01996), Removal (62355), Fluoroscopy (77003), and inpatient stay x 1 day.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
Dr.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr. : Interim History and Physical – 8/20/08 - 10/6/08 and History & Physical – 7/30/08.

Records reviewed from : LVN denial letter – 9/11/2008 & 9/23/2008; Pre-authorization request – 9/8/08 & 9/15/08; Plan of Care – 8/20/08; and PHD report – 8/14/2008.

The ODG is cited in the denial letter ; however, a copy of the ODG was not provided.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured at work when twisting at the trunk to board a truck. He had thoracic pain. T12/L1 HNP was verified via MRI. He underwent ESI x3 at the thoracic level. Dr. notes that he was injured when twisting at his desk. In the past, the patient has undergone lumbar laminectomy and discectomy as well as ACDIF at the cervical level. He has also undergone management with several oral opiate agents including Oxycontin, Oxycodone, Ultram, Ultracet, and a Duragesic patch. He is managed with Lamictal, Topamax, and Effexor.

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

- The ODG indicate the following criteria for an IIDDS. 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:

  1. Documentation, in the medical record, of the failure of 6 months of other conservative treatment modalities (pharmacologic, injection, surgical, psychologic or physical), if appropriate and not contraindicated; (this criterion is met) and
  2. Intractable pain secondary to a disease state with objective documentation of pathology in the medical record (per symptoms, exam and diagnostic testing); (this criterion is met, there is MRI evidence of an HNP at T12-L1 and
  3. Further surgical intervention or other treatment is not indicated or likely to be effective; (this criterion is met) and
  4. 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; (this criterion is met) and
  5. No contraindications to implantation exist such as sepsis, spinal infection, anticoagulation or coagulopathy; (This criterion is met as per the records provided; however, pre-operative bloodwork will be necessary) and
  6. 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 1-5 above are met.

The previous denials were based on a lack of documentation of trial oral analgesics and documentation of a psychological screening. As of the time of this review, the reviewer indicates that both of these procedures have been offered. Because all of the ODG criteria for this procedure have been met, this requested service is approved as medically necessary.

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**
- ☐ **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**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**