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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/14/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Pump Refill/Programming-Lumbar; CPT Codes 62368, 95991, 77003

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

MD, Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and Orthopedic Surgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Adverse Determination, 6/29/09

DO, 7/6/09, 7/7/03, 7/28/03, 8/28/03, 10/16/03, 9/25/03,
11/6/03, 11/25/03, 12/18/03, 1/19/04, 3/22/04, 4/19/04, 5/17/04, 6/14/04,
8/9/04, 9/27/04, 10/25/04, 12/6/04, 1/3/05, 2/21/05, 1/31/05, 3/28/05,
4/25/05, 6/21/05, 6/22/05, 7/20/05,

Anesthesiology, 3/17/09, 6/4/09

Labs, 6/4/09

Chart of Refills, 7/26/05-6/4/09

History and Physical Exam, 3/4/08

9/21/06, 7/20/05

MRI of the Thoracic and Lumbar Spine, 9/12/03

MD, 8/25/03

PhD & Associates, 5/19/05

Intrathecal opioid trial with fentanyl, 6/21/05

Placement of programmable pump with intrathecal catheter, 7/26/05

Operative Reports, Interrogation and Programming of SynchroMed pump,
8/11/05, 8/31/05, 9/8/05, 8/4/05, 10/31/05, 1/23/06, 6/15/06, 4/17/06,
9/26/06, 12/14/06, 3/5/07, 5/14/07, 8/31/07, 3/27/08, 6/30/08, 10/2/08,

11/13/08, 11/25/08, 12/30/08, 2/25/09, 3/17/09, 5/12/09,
Operative Report, Contrast study of pump and catheter with myelogram and
followup CT scan, 3/28/07
MD, 3/24/08

PATIENT CLINICAL HISTORY SUMMARY

This man was injured in xxxx/xxxx. He subsequently had a laminectomy from L4 to the Sacrum and for spinal stenosis with radiculopathy in 2001. The surgery included a repair of a large dural tear. He continued to be symptomatic. A spinal pump was inserted in July 2005 for his failed back syndrome. He has had progressive increase in the use of the Fentanyl. The largest volume increase has been in the last 6 months when the amount almost doubled, but percentage increases have been common at almost every refill for this man since its insertion in July 2005. He has seen Dr. for several IMEs. The most recent was in March 2008. Dr. had previously agreed to the use of the pump. He noted the almost complete absence of the use of oral medications for pain control. Dr. felt this man can work. Dr. noted in the 6/4/09 report that he was more mobile and worked about the house. Dr. had concerns over drug screens. The one done on 6/4/09 showed no unanticipated findings. Dr. has questioned the level of pain and the man's functional level.

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

The prior denials are apparently due to lack of documentation of functional improvement, pain control and the amount of medication used. Records indicate a progressive increase in the total use of the opiates. This was a slow qualitative increase initially, but the amount was and continues to exponentially increase. However, there is substantial documentation that the medication is helping. Dr. wrote of this in his last note. Dr. 's note from March 2008 showed that he felt there was significant pain relief and that this man could possibly work. In addition, Dr. had the urine drug screen that was concerning to Dr. The screen done on 6/4/09 showed no unanticipated findings. There is nothing in the records provided that should preclude this man from ongoing treatment. The request meets the guidelines. The reviewer finds that medical necessity exists for Pump Refill/Programming-Lumbar; CPT Codes 62368, 95991, 77003.

Implantable drug-delivery systems (IDDSs)

Recommended only as an end-stage treatment alternative for selected patients for specific conditions indicated below, after failure of at least 6 months of less invasive methods, and following a successful temporary trial. Results of studies of opioids for musculoskeletal conditions (as opposed to cancer pain) generally recommend short use of opioids for severe cases, not to exceed 2 weeks, and do not support chronic use (for which a pump would be used), although IDDSs may be appropriate in selected cases of chronic, severe low back pain or failed back syndrome. This treatment should only be used relatively late in the treatment continuum, when there is little hope for effective management of chronic intractable pain from other therapies. (Angel, 1998) (Kumar, 2002) (Hassenbusch, 2004) (Boswell, 2005) (Deer, 2009) For most patients, it should be used as part of a program to facilitate restoration of function and return to activity, and not just for pain reduction. The specific criteria in these cases include the failure of at least 6 months of other conservative treatment modalities, intractable pain secondary to a disease state with objective documentation of pathology, further surgical or other intervention is not indicated, there are no contraindications to a trial, psychological evaluation unequivocally states that the individual has realistic expectations and the pain is not psychological in origin, and a temporary trial has been successful prior to permanent implantation as defined by a 50% reduction in pain.

Refills: IDDSs dispense drugs according to instructions programmed by the clinician to deliver a specific amount of drug per day or to deliver varying regimens based on flexible programming options, and the pump may need to be refilled at regular intervals. The time between refills will vary based on pump reservoir size, drug concentration, dose, and flow rate. A programming session, which may occur along with or independent of a refill session, allows the clinician to adjust the patient's prescription as well as record or recall important information about the prescription. (Hassenbusch, 2004) ...

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

ACOEM-AMERICA 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)