DATE OF REVIEW: 06/25/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Replacement of Six-Year-Old Pump (Morphine) and Catheter

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

Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Report of Operation, , M.D., 02/15/96, 07/27/00
- Follow Up Visit, M.D., 02/07/08, 04/03/08, 06/05/08, 08/30/08, 12/30/08, 04/30/09
- Synchromed Pump Refill, Dr. 02/07/08, 04/03/08, 06/05/08, 08/07/08, 10/09/08, 12/05/08, 02/12/09
- Case Management Note, Dr., 04/30/09

- Case Report, 05/12/09
- Denial of Pre-Authorization or Concrurrent Review Request, , 05/14/09
- Physician Determination – Initial Appeal, , 05/26/09
- Denial of Reconsideration of Pre-Authorization or Concurrent Review Request, , 05/29/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient underwent an anterior lumbar discectomy at L4-5 and anterior lumbar interbody fusion, using allograft bank bone. Placement of BAK anterior segmental stabilization instrumentation at L4-5, right was also performed. He underwent another surgery that included a posterior lumbar interbody fusion at L5-S1 and placement of intradiscal devices at L5-S1. He was conservatively treated by Dr. and returned approximately every two months for refills for his Morphine pump. It was reported that he occasionally took Klonopin and Vicodin as well. Other medications were reported as Nexium, Cardizem, Tricor, Fosamax, and testosterone.

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

Services in dispute are replacement of intrathecal pump and catheter. Upon independent review, the reviewer finds that the previous adverse determinations/determinations should be upheld.

First and foremost, there is absolutely no current evidence that the currently-implanted pump is malfunctioning, nor that the currently implanted catheter has any dysfunction. There is no documentation of the implanted intrathecal pump alarm going off, nor is there any indication, nor for that matter, even any suspicion by Dr. that the catheter pump or catheter are malfunctioning in any way. There is absolutely no medical reason, necessity or justification for implanting the pump when there is no evidence of its dysfunction, regardless of the age of the pump. Additionally, there is little to no documentation that the intrathecal medications being given this patient are providing any objective evidence of significant pain relief or functional improvement. Moreover, the claimant has required increasing doses of intrathecal morphine. Over the last sixteen months, in fact, the dose of morphine has increased almost 20%, and during that time the claimant has gone from utilizing no oral breakthrough medication to currently using significant amounts of hydrocodone for breakthrough medication. There is, therefore, in my opinion a significant question as to whether the intrathecal medications are providing this claimant with significant pain relief. There is, in fact, no objective documentation by Dr. in any of the progress notes over the last sixteen months regarding the claimant's pain level nor any documentation whatsoever of improvement in the claimant's functional status. The physical examination documented by Dr. indicates that the claimant continues to have chronic intractable pain and limitation of functioning. Additionally, it appears that the

claimant is being considered for further cervical spine surgery. In summary, there is no medical reason or necessity for the current intrathecal pump or catheter to be replaced as there is no current evidence of pump or catheter dysfunction. Additionally, the medical necessity of replacing the pump, even if there were a pump dysfunction, is questionable based on the lack of objective evidence of significant clinical efficacy through the use of intrathecal medication. The recommendations of the two previous physician reviewers for nonauthorization of the requested procedure are, therefore, upheld as being appropriate.

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)**