



Notice of Independent Review Decision

DATE OF REVIEW: 10/20/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Pump Refill, Refill Kit, Pump Programming

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

Board Certified in Physical Medicine and Rehabilitation

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.

PUMP REFILL – OVERTURNED
REFILL KIT – OVERTURNED
PUMP PROGRAMMING - OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Re-evaluation, D.O., 07/07/03, 07/28/03, 08/28/03, 09/25/03, 10/16/03, 01/19/04, 02/23/04, 03/22/04, 04/19/04, 05/17/04, 06/14/04, 07/12/04, 08/09/04, 09/27/04, 10/25/04, 12/06/04, 01/03/05, 01/31/05, 02/21/05, 03/28/05, 04/25/05, 07/20/05
- Physician's Statement of Medical Necessity/Prescription, M.D., 07/14/03, 01/07/05
- Evaluation, M.D., 08/25/03, 07/19/04
- MRI Thoracic and Lumbar Spine, M.D., 09/12/03
- Operative Report, Dr., 11/06/03, 11/25/03, 12/18/03, 06/21/05, 08/04/05, 08/11/05, 08/31/05, 09/08/05, 10/31/05, 01/23/06, 04/17/06, 06/15/06, 09/26/06, 11/01/06, 12/07/06, 12/14/06, 03/05/07, 03/08/07, 05/14/07, 08/31/07, 12/13/07, 03/27/08, 06/30/08, 10/02/08, 11/13/08, 11/25/08, 12/30/08, 02/25/09, 03/17/09, 05/12/09, 07/14/09, 07/28/09, 08/25/09, 09/21/09, 10/12/09
- Medical Prescription, Dr., 01/19/04
- Independent Medical Examination (IME), M.D., 07/27/04, 10/05/09
- Behavioral Medicine Evaluation, Ph.D., 05/19/05
- Discharge Summary, Dr., 06/22/05
- Progress Note, M.D., 07/01/05, 12/18/06, 03/05/07, 06/20/07, 07/15/09
- Required Medical Evaluation (RME), Dr., 07/20/05, 09/19/06, 03/04/08
- Correspondence to Access LLC, 07/21/05
- Operative Report, Dr., 07/26/05, 03/28/07
- Office Visit Worksheet, , 03/08/06, 04/17/06
- Pump Contrast Study, M.D., 03/28/07
- CT Lumbar Spine, Dr. , 03/28/07
- Toxicology Screen, Ltd., 12/13/07
- Toxicology Screen, Laboratories, 06/04/09
- Notification of Determination, 06/29/09, 09/03/09, 10/01/09
- Programming Session, Unknown Provider, 07/09/09, 08/25/09, 09/21/09
- MRI of the Lumbar Spine, M.D., 07/09/09
- Record Review, M.D., 09/08/09
- Pre-Authorization Request, Dr., 09/28/09, 10/05/09
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured on xx/xx/xx while moving a machine. He injured his lower back. He underwent MRI's of the cervical and lumbar spine. He was treated with physical therapy and then underwent a L4-L5 and L5-S1 laminotomy/laminectomy. Approximately six caudal epidural blocks were performed. He was then placed on an intrathecal opioid pump.

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

The pump refill, refill kit, and programming do appear to be medically reasonable and necessary. While I agree with previous reviewers that the documentation is oft-times confusing, documents are provided that the patient has been receiving regular refills and adjustments to his medications at regularly scheduled medical visits since 07/26/05. His medication use has varied somewhat and the physician does appear to be titrating medication use to the patient's function based upon provided documentation. Furthermore, abrupt withholding of this medication would likely result in significant harm to the patient by way of medication withdrawals and may ultimately result in seizures. As such, the requested service of pump refill with programming requiring a refill kit appears to be reasonable and necessary.

In addition, the Official Disability Guidelines require documentation of improvement in function for continued use of intrathecal pump medication. The patient's function has been documented throughout the course of treatment based upon the records provided, and the patient's dysfunction has been also identified and does appear to be correlated with quantity of medication use. As such, the above intervention does appear to be reasonable and 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)**