

# Prime 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/28/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Bump up on the intrathecal morphine pump and programming neck only

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Board Certified in Pain Management

**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)

**PATIENT CLINICAL HISTORY SUMMARY**

This woman was injured in xx/xxxx and apparently developed complex regional pain syndrome of the lower extremities. She had secondary cellulitis in the summer of 2009 and her pain worsened. Dr. apparently increased the pump Dilaudid (currently 8mg) necessitating earlier refills. Her new alarm date was 10/23/09. She apparently improved with sympathetic blocks, the last being 9/23/09. The request is for a bump up on the intrathecal morphine pump and programming neck only.

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

According to the medical records, there has been an increase in this patient's pain, not responsive to oral medications. The ODG criteria is met for the IDDS. Dr. planned for this to be temporary. The reviewer finds that medical necessity exists for Bump up on the intrathecal morphine pump and programming neck only.

Implantable drug-delivery systems (IDDSs)

Recommended only as an end-stage treatment alternative for selected patients for specific conditions indicated below...

Indications for Implantable drug-delivery systems:

Implantable infusion pumps are considered medically necessary when used to deliver drugs for the treatment of

- o Primary liver cancer (intrahepatic artery injection of chemotherapeutic agents)
- o Metastatic colorectal cancer where metastases are limited to the liver (intrahepatic artery injection of chemotherapeutic agents)
- o Head/neck cancers (intra-arterial injection of chemotherapeutic agents)
- o Severe, refractory spasticity of cerebral or spinal cord origin in patients who are unresponsive to or cannot tolerate oral baclofen (Lioresal®) therapy (intrathecal injection of baclofen)

Permanently implanted intrathecal (intraspinal) infusion pumps for the administration of opiates or non-opiate analgesics, in the treatment of chronic intractable pain, are considered medically necessary when

· Used for the treatment of malignant (cancerous) pain and all of the following criteria are met:  
...

· 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; and
2. Intractable pain secondary to a disease state with objective documentation of pathology in the medical record (per symptoms, exam and diagnostic testing); and
3. Further surgical intervention or other treatment is not indicated or likely to be effective; 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; and
5. No contraindications to implantation exist such as sepsis, spinal infection, anticoagulation or coagulopathy; 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.

**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)