

SENT VIA EMAIL OR FAX ON
Oct/19/2010

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Pump Refill; Pump Programming; Fluoroscopy; Refill Kit

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC 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

OD Guidelines

Denial Letters 10/4/10 and 9/23/10

Anesthesiology 9/28/10-10/12/10

9/29/10-10/12/10

CNS 5/10/10

IRO Summary 10/18/10

418 Pages from Group 12/26/1998-10/15/10

Dr. 8/2000-10/2010

PATIENT CLINICAL HISTORY SUMMARY

This is a woman injured on xx/xx/xx. She apparently had a failed laminectomy. She had a pump implanted in 2001 and is currently on Fentanyl, bupivacaine, and Dilaudid in the pump. She has a sensorimotor polyneuropathy and restless leg syndrome. He is on clonazepam per her neurologist, Dr.. She had a knee replacement last winter and has been on Oxycodone/Percocet. Dr. has been managing this. He wrote in his 10/4/10 note of the importance of the pump refill, the risks if not refilled and how this lady has had functional

improvement with the pump.

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

The request to refill the pump is medically necessary. The situation is urgent. The lady had been receiving Oxycodone, but with Dr. knowledge. Clonazepam is a secondary drug, once the only drug, for restless leg syndrome. This information is presented and explains the UDT findings. Most of the ODG discusses the justification for the initiation of the pump. There has been functional improvement and no contraindication to its ongoing use.

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)