

Notice of Independent Review Decision

DATE OF REVIEW: 10/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Revision of Pump and Catheter

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

The physician performing this review is Board Certified, American Board of Anesthesiology with a specialty in Pain Management and Diplomate, National Board of Examiners. He is currently an Attending Pain Management Specialist at a University Hospital. He is a Member of the American Society of Anesthesiologists, Society for Education on Anesthesia, and International Anesthesia Research Society.

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.

The patient has had a pump in place for several years and the patient is doing well. Based on ODG guidelines a revision of the pump is appropriate and certified.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records received: 16 page fax 10/18/10 10 Texas Department of Insurance IRO request; 93 page fax 10/18/10 URA Response to disputed services with administrative and medical records

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient has a history of low back pain and has had an intrathecal pump in place since 2004 with good relief. It was noted on 9/22/10 that the pump is malfunctioning. The request is for revision of intrathecal pump.

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

Official disability guidelines states the following "Implantable drug-delivery systems (IDDSs)-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, 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; 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 and that benefit would occur with implantation despite any psychiatric comorbidity; and
5. No contraindications to implantation exist such as sepsis 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.

This patient meets the criteria as outlined in the ODG guidelines. The patient has had a pump in place for several years and the patient is doing well. Based on ODG guidelines a revision of the pump is appropriate and certified.

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 Treatment Index, 6th Edition (web), 2008, pain chapter
Implantable drug-delivery systems
- 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

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FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

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