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## Notice of Independent Review Decision

**DATE OF REVIEW:** 01/20/11

**IRO CASE #:**

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

Trial of lumbar intrathecal narcotic pump

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

Board Certified in Orthopedic 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)

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.

Trial of lumbar intrathecal narcotic pump - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

## **PATIENT CLINICAL HISTORY**

On 12/23/04, Dr. recommended a therapeutic S1 root block and a possible repeat MRI. ESIs were performed with Dr. on 01/11/05, 02/22/05, and 04/19/05. On 05/03/05, Dr. stated there was nothing further to offer the patient. A C5-C6 and C6-C7 anterior cervical discectomy and microsurgical osteophyte dissection with arthrodesis and plate and screw fixation, as well as a left carpal tunnel release were performed by Dr. on 02/09/09. On 03/24/09, Dr. recommended an MRI of the left shoulder. On 06/01/09, an unknown provider at prescribed a Lidoderm patch and Soma. On 12/11/09, the unknown provider recommended an EMG/NCV study and tapered Prednisone. An EMG/NCV study on 01/05/10 occurred, but the results were unknown. On 07/19/10, Dr. recommended psychological clearance for a spinal cord stimulator trial, Lortab, Neurontin, and a home exercise program. On 08/05/10, Dr. provided psychological clearance for a spinal cord stimulator. On 08/16/10, Dr. recommended a spinal cord stimulator trial, continued Neurontin, Norco, and continued home exercises. On 08/30/10, Dr. cleared the patient for spinal cord stimulator surgery. On 09/24/10, Dr. performed spinal cord stimulator placement and programming. On 11/05/10, Dr. recommended a trial intrathecal narcotic injection. On 11/16/10, Dr. wrote a letter of non-certification for a lumbar trial of intrathecal narcotic pump. On 11/30/10, Dr. wrote a letter of reconsideration. On 12/01/10, Dr. wrote a letter of non-certification for the intrathecal narcotic pump. On 12/03/10, Dr. prescribed Percocet and discussed a repeat MRI. On 12/11/10, Dr. wrote another precertification request for the intrathecal narcotic pump.

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

The patient is using very low doses of narcotics and is not receiving any relief. There is no indication that she has been trialed with anti-neuropathic agents nor anti-inflammatory agents. It does not appear that conservative treatment has been exhausted at this time. The ODG indicates that implantable drug delivery systems are recommended only as an end stage treatment alternative for selective patients, with failure of at least six months of less invasive methods, following a successful temporary trial. This patient does not meet that criteria. Therefore, the requested trial of lumbar intrathecal narcotic pump would be neither reasonable nor necessary for this patient, as she does not meet the specific criteria promulgated by the ODG. The previous adverse determinations should be upheld.

## **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 AND KNOWLEDGE BASE
- 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)