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Notice of Independent Review Decision

AMENDED REPORT 1/14/2011

DATE OF REVIEW: 1/14/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an outpatient pump trial (62311 and 77003).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation with a second specialty in Pain Management. The reviewer has been practicing for greater than 15 years.

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)

The reviewer agrees with the previous adverse determination regarding the the prospective medical necessity of an outpatient pump trial (62311 and 77003).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured when attempting to catch a glass plate. He has undergone treatment with physical therapy, work hardening, and injections. He is managed with narcotic analgesics, Baclofen, and Neurontin.

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

ODG Indications for Implantable drug-delivery systems:

Implantable infusion pumps are considered medically necessary when used to deliver drugs 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.
2. Intractable pain secondary to a disease state with objective documentation of pathology in the medical record (per symptoms, exam and diagnostic testing). **There is no documentation of any verifiable or compensable pathology.**
3. Further surgical intervention or other treatment is not indicated or likely to be effective. **There is no documentation of any certifiable or compensable pathology requiring surgical intervention.**
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. **There is no documentation of any recent psychological evaluation. The most recent one was done on 3/17/09.**
5. No contraindications to implantation exist such as sepsis, spinal infection, anticoagulation or coagulopathy. **There is no documentation of any risk of anticoagulation. There is documentation of lower extremity edema, but there is no documentation of the work up of the source of the edema.**
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.

There is no documentation of any temporary trial of a spinal opiate administration system.

There is not sufficient documentation to support the authorization of an implantable drug delivery system (pain pump); therefore, the request is not medically 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)