

Notice of Independent Review Decision

DATE OF REVIEW: 05/21/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient revision of pump and possible revision to catheter lumbar spine

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering chronic low back pain and failed back syndrome

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment forms
2. Letters of denial, 04/15/11 and 04/29/11 including criteria used in the denial
3. Preauthorization request, 04/12/11
4. Operative reports, 04/18/11 and 05/12/11
5. Progress note, 04/06/11

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
			<i>Prosp.</i>						<i>Upheld</i>

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a female who suffered an injury to her lumbar spine in a work-related accident on xx/xx/xx. She underwent surgeries to the lumbar spine in 1998, and revision surgery in 2000. She has subsequently suffered chronic lumbar pain. In 2002 a morphine pump was placed for continuous delivery of intrathecal anesthetic, and the pump has been appropriately delivering intrathecal medication for a period of approximately nine years. She undergoes periodic replenishment of the medication and periodic inspection of the pump function. Currently the pump is functioning at 80-85% of functionality. A recent request to have the pain pump replaced was submitted on the basis of its presence for a period of nine years. This request was denied, and it was reconsidered and denied.

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

It would appear that this pump is functioning appropriately in spite of the fact that it has been present for nine years. The duration of the pump activity is not a clear indication for its replacement. In the absence of evidence of impending pump failure, it would be inappropriate to preauthorize pump replacement revision. The recent denials were appropriate and should be upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)