

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** May 16, 2011

**IRO CASE #:**

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

Intrathecal pump implant trial.

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

Fellow American Academy of Physical Medicine and Rehabilitation  
Member of PASSOR

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**Health Direct, Inc.:**

- Office visits (11/24/10 – 03/15/11)

**Medical Center:**

- Office visits (11/04/04 – 04/13/11)

**TDI:**

- Utilization reviews (04/04/11 – 04/14/11)

**ODG has been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained injury to his lower back on xx/xx/xx. The exact mechanism of injury is unknown.

**1997 – 2003:** No records are available.

**2004 – 2009:** According to a medication list, the patient was treated from November 2004 through April 2009 by M.D., with methadone, Neurontin, Xanax, Ambien, Cymbalta, prednisone taper, Lunesta, Avinza, Paxil CR, Phenergan, Lyrica, Lidoderm patches, OxyContin IR, Flexeril, MS Contin, promethazine, Viagra, Opana ER, Ambien CR and Duragesic patches.

In October 2009, Dr. noted the patient had been recently hospitalized as he had run out of medications due to improper use/abuse of opiates. He was

discharged with OxyContin, alprazolam and Lyrica. Examination revealed mild left lower extremity weakness and altered sensation to the left leg. Dr. diagnosed failed back syndrome, chronic low back pain, neuropathic pain, anxiety and opiate addiction. He recommended detoxification with Suboxone.

**2010:** In January, Dr. noted that the patient was seen by an addictionologist. He was utilizing Seroquel, Pristiq, Lyrica and Suboxone. He reported an itching sensation and tightness of face and pain referring into lower extremities intermittently. Dr. opined that the patient should never use opiate pain medications and recommended follow-up with the addictionologist and changing Lyrica to Neurontin.

On follow-up, Dr. noted the patient had been hospitalized and detoxed from Suboxone. He was utilizing diazepam, Pristiq, Ambien and gabapentin. The patient complained of intense muscle spasms in the lumbar region. Dr. requested for physical therapy (PT).

On follow-up, the patient complained of severe increase in pain and very poor sleep. Examination showed decreased range of motion (ROM) and increased tenderness to the lumbar region. Dr. gave samples of Pennsaid lotion and Flector patch and recommended a trial of intrathecal pump. The patient reported better quality of life and was maintained on Neurontin, diazepam and Ambien CR. He was instructed on proper body mechanics.

**2011:** In February, the patient complained of uncontrolled low back pain. He had tried to manage his pain non-pharmacologically without any relief. Dr. prescribed hydrocodone 10/325 and recommended a trial of intrathecal pump. Dr. opined if the patient passed the trial and a permanent pump was implanted, then oral opiates could be totally eliminated.

In March, Dr. noted that the patient perceived his quality of life as better with the opiate pain relievers. Urine toxicology screening was appropriate. Dr. opined that long-acting opiate pain relievers would better manage the pain than short acting. He prescribed morphine sulphate 15 mg and recommended continuing hydrocodone, diazepam and Neurontin.

Per utilization review dated April 4, 2011, the request for trial of intrathecal pump was denied with the following rationale: *“The request for trial intrathecal pain pump was not certified. At this point it does not appear that the claimant has been exhausted on opioid medications. The claimant has recently been taking hydrocodone 10 up to four times a day, which for chronic pain is a relatively low dose. The claimant has just been recently escalated to morphine sulfate 15 mg b.i.d. It is unclear how he will respond to this. It does not appear that the claimant has failed strong opioids or analgesics at this point based on the records provided. Additionally, it is uncertain what the claimant’s diagnosis is. The claimant has basically been treated for chronic low back pain with radicular symptoms. MRI results were not provided to determine source or generator of the claimant pain. It does not appear that this patient has severe spasticity nor has the claimant had previous spine surgery. There is no documentation that further surgical treatment may or may not be indicated, nor any documentation of any psychological evaluation. Denied per Official Disability Guidelines criteria. This request is not certified.”*

On April 13, 2011, the patient reported that the pain was not managed well and increased with increased physical demands at work. Examination revealed decreased sensation to the left lateral leg. Dr. increased morphine sulfate to 30

mg and recommended continuing hydrocodone, diazepam and Neurontin and requested psychological evaluation for intrathecal pump trial.

In a reconsideration review dated April 14, 2011, the evaluator noted that the patient had undergone three back surgeries, a microdiscectomy of the lumbar spine, a second surgery for fusion and an operation sometime around 2007 where there was a redo and hardware removal. The request for trial intrathecal pump was denied with the following rationale: *“According to the medial records, the patient is a individual who sustained an industrial injury on xx/xx/xx. A March 15, 2011, office visit note by Dr. was handwritten and partially illegible. It is noted that hydrocodone helps lessen the pain. It is also noted that the patient is working 9 am to 6 pm. The patient reports that he perceives his quality of life as better with use of opiate pain relievers. Dr. notes that long-acting opiate pain relievers would better manage his pain than short-acting. Diagnoses included failed back syndrome, chronic pain, lumbar radiculopathy, neuropathic pain, and well-controlled anxiety. Treatment plan includes morphine sulfate 50 mg, continue hydrocodone, diazepam, Neurontin, intrathecal pump trial and pill count next visit. Peer review by Dr. was performed on April 4, 2011, at which time recommendation was given to non-certify the request for a trial intrathecal pain pump. It was noted that it does not appear that the patient has been exhausted on opioid medications. It was also noted that the patient has recently been taking hydrocodone 10 up to 4 times a day, and the patient has just been recently escalated to morphine sulfate 15 mg b.i.d. Additionally, it was noted that it does not appear that the patient has severe spasticity, that further surgical treatment may or may not be indicated, or documentation of any psychological evaluation.”*

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

Injured worker reportedly with subjective increasing low back pain associated with subjective lower extremity referral pain with no report of acute measured functional deterioration. Documentation reveals injured worker still capable of full time gainful employment. There is no report of current p.o. analgesics being maximized for attempted pain control. Recent treatment notes do indicate improvement in pain with opioid analgesics of which current use of morphine sulfate has not been maximized in terms of response to pain treatment. There is no report regarding recent diagnostic studies to assess his subjective increased pain pattern with a history of 3 lumbar surgeries to rule out the potential need of additional surgery. In addition there is no comprehensive psychological assessment conducted to rule out any psychiatric/behavioral disorder that would contraindicate the pain pump trial request.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES