SENT VIA EMAIL OR FAX ON
May/04/2011

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
ITP Replacement

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Anesthesiologist/Pain Management

REVIEW OUTCOME:

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

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines

1. Cover sheet and working documents
2. Utilization review determination dated 03/17/11, 04/12/11, 06/07/00, 08/31/00, 10/30/00, 03/19/02
3. Operative report dated 05/03/02, 02/05/03, 02/12/03, 06/26/03, 01/19/99, 01/03/01, 03/08/02, 04/19/02
4. Medical records Dr.
5. Handwritten notes Occupational and Environmental Health Services dated 2004
6. Medical records Dr.
7. Medical records Dr.
8. Psychiatric evaluation dated 01/12/05
9. Medical records Dr.
10. Medical records Dr.
11. Medical records Dr.
12. IME dated 04/30/08 Dr.
13. MRI lumbar spine dated 10/03/08, 07/20/00, 03/28/02
14. Neurosurgical consultation dated 08/29/00
15. Physical therapy notes
16. Peer review dated 07/10/02
17. Attorney letter dated 06/12/06
18. Appeal letter dated 03/10/11
19. Letter of medical necessity dated 03/04/09
20. Medtronic reference material
21. Intrathecal pump refill procedure reports

22. EMG/NCV dated 03/03/09, 09/12/00
23. Medical records Dr.
24. dated 03/17/10
25. Medical records Dr.
26. Employee's request to change treating doctors dated 11/24/99
27. Massage therapy notes

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. On this date the patient strained his lower back. The patient is status post right sided L5 and S1 laminotomies, right sided L5-S1 re-exploration with epidural scarlysis and L5-S1 discectomy on 01/03/2001. Treatment to date is noted to include epidural steroid injections, surgical intervention, medication management, massage therapy and spinal cord stimulator trial in 2002. The patient underwent implantation of intrathecal catheter on 02/05/03 with revision on 02/12/03 and 06/26/03. The patient has subsequently undergone multiple intrathecal pump refills. Pain management evaluation dated 10/13/04 indicates that the patient reports that the pump has given him some limited pain relief, but complains of nausea. The patient was recommended to begin weaning off the pain pump. The patient underwent epidural adhesiolysis via Racz catheter right L5-S1 on 11/09/04. The patient continued with pump refills in 2004, 2005, 2006, 2007 and 2008. IME dated 04/30/08 indicates that the patient is status post lumbar surgery x 2. The patient's intrathecal pain pump has been effective in controlling his pain and has allowed him to return to be functional and has no side effects. MRI of the lumbar spine dated 10/03/08 revealed diffuse disc bulge at L5-S1 and mild bilateral facet degeneration of the lower lumbar spine. EMG/NCV dated 03/03/09 revealed evidence which is consistent with a diagnosis of either a low lumbar central spinal stenosis and/or a peripheral polyneuropathy. The patient continued with pump refills throughout 2009 and 2010. IME dated 03/17/10 indicates that the patient is working full time and the intrathecal pain pump controls his pain and allows him to function. Office visit note dated 01/07/11 indicates that the pump is 7 ½ years old and not as effective in controlling pain. Office visit note dated 03/11/11 indicates that the patient is having no difficulty with ambulation and is able to perform ADLs. The patient continues to work full time. The patient had intense back pain but is better, and the patient thinks it may have been a kidney stone.

Initial request for ITP replacement was non-certified on 03/17/11 noting that the patient is requiring increased amounts of medication at refills and has had the current unit for 8 years. The requesting physician opines that the increased delivery of medication is an indication of failure of the unit. There is no indication that the unit's delivery ability has been tested with dye to rule out any catheter issues. No diagnostic report of the unit was provided for review of the unit noting any failures of the unit. The denial was upheld on appeal dated 04/12/11 noting that the provider maintains that the patient is able to continue his work schedule and function as a member of society because of the good results of his pump. The patient has been very stable with his dosing over the last several refills into the 8th year of his pump. No documentation was submitted noting any manufacturer recommendations for pump replacement due to age, any diagnostic testing to support a quantifiable malfunction of current pump nor evidence that catheter failure has been eliminated.

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

Based on the clinical information provided, the request for ITP replacement is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent intrathecal pump placement approximately 8 years ago and has undergone multiple subsequent pump refills with good results. Office visit note dated 01/07/11 indicates that the pump is 7 ½ years old and not as effective in controlling pain. However, office visit note dated 03/11/11 indicates that the patient is having no difficulty with ambulation and is able to perform ADLs. The requesting provider opines that the unit is not functioning properly due to its age and the patient's recent increased medication usage. However, there is no diagnostic testing provided to support that the unit is malfunctioning or to establish that the possibility of catheter failure has been assessed. There are no manufacturer recommendations for pump replacement provided, and no detailed assessment of the current

unit was submitted for review. Given the current clinical data, the request is not indicated as medically necessary, and the two previous denials are upheld.

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

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)