MEDRx

3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 10-30-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of three day inpatient stay for placement of permanent intrathecal infusion pump of the lumbar spine at Pine Creek Medical Center as requested by Dr.

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 Anesthesiology. This reviewer has been practicing for greater than 10 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 three day inpatient stay for placement of permanent intrathecal infusion pump of the lumbar spine at Medical Center as requested by Dr.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Risk Management Fund and Dr.

These records consist of the following:

paperwork
preauthorization determinations 9-1-11, 9-20-2011
Preauthorization requests 8-29-2011, 9-13-2011
DO records 10-3-2011, 9-6-2011, 8-22-2011, 6-13-2011, 5-19-2011, 1-24-2011, 1-17-2011, 1-3-2011, 9-13-2011, 6-29-2011, 5-9-2011
Operative Report 8-16-2011
Center for Diagnostics & Surgery report 9-8-2010
Medical Center report 2-3-2009
University report 9-22-1999
Rehabilitation report 7-7-2011
Associates report 8-8-2005
Prospective Review response 10-11-2011 including 13 exhibits

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a work related injury on xx/xx/xx while working. According to the documentation, As a result he felt pain in his lower back.

Compensable injury is reported to the lumbar spine status post failed surgery x 2 with residual chronic pain. Initial treatment was conservative and eventually, the claimant underwent a 360 spine surgery in 1994. Second surgery date is unknown. Additional treatment has been extensive.

The claimant reported that for this injury he has had numerous x-rays, MRI's, CT scans, 2 discograms, and several myelograms. He stated that he has been treated with several steroid injections. He has had ultrasound therapy, heat/ice, physical therapy modalities and the use of TENS unit. After the 360 surgery, improvement was reported. Then, he has had periods of pain and other times of some relief but slowly he has gotten worse and according to the records has a 100% disability at this time.

Most recently, the claimant has been treated with chronic pain management, steroid injections, use of medication and a trial of intrathecal narcotic pump.

Current medications are Lyrica 100 mg tid, Amitryptyline 25 mg qhs, Norco 10/325 mg every 4 hours, Ambien 10 mg q pm and other unknown medication for stomach PRN.
On 8/22/11, Dr. stated in his medical notes that the claimant called from his home in San Antonio to report the three day trial for intraspinal narcotic solution went extremely well. He and his wife remarked he was over 100% better. He was more functional and more active. In fact, when the catheter was pulled on Thursday, his pain did not return after the 5 mg epidural dose until early Saturday morning. In Dr. opinion, the claimant fits the criteria for intraspinal infusion pump system.

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

Based on the records submitted for review, the requested procedure is not recommended at this time. Patient has not had any long-term trial of long acting opioids. There has been no recent myelogram/CT since 09/09 to determine if there is a potentially repairable structural problem. The 'trial' included epidural steroids in addition to the opioids, so it is possible that the short-term pain relief was attributable to the steroid not the opioids. Therefore, the patient is not a candidate for the pump implant.

According to the Spine Treatment Guideline, treatment of a work related injury must be adequately documented and evaluated for effectiveness. Per the Official Disability Guidelines criteria, a temporary trial of spinal (epidural or intrathecal) opiates has been considered 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.

Per the Official Disability Guidelines, there are criteria (1 to 6) regarding implantable drug delivery systems (IDDs). A temporary trial of intrathecal (intraspinal) infusions pumps is considered medically necessary only when criteria 1-5 of the ODG are met. It is unclear if the pain relief was actually from the trial or epidural steroid injection.

Therefore, the performance of a three day inpatient stay for placement of permanent intrathecal infusion pump of the lumbar spine at Pine Creek Medical Center as requested by Dr. in a patient without clear evidence of pain relief obtained directly from the pump trials required by the ODG is not supported and is not medically reasonable or necessary at this time.

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition
Chapter: Pain

Used 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, psychological 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); and
3. Further surgical intervention or other treatment is not indicated or likely to be effective; and
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 the benefit would occur with implantation despite any psychiatric comorbidity; and

5. No contraindications to implantation exist such as sepsis, spinal infection, anticoagulation or coagulopathy; and
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.

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)**