

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 26, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s). (Trial of intraspinal morphine)

CPT Codes 62311 x 3, 77003 x 3 and 01992 x 3

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

This case was reviewed by a Physician licensed in Texas since 1992 who holds a certification by the American Board of Anesthesiology with sub-certifications in Pain Medicine.

REVIEW OUTCOME

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

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Received	Date(s) of Record
Request for review by IRO for the denied services of pump trial (x3) separate days; fluoroscopy (x3) separate days; anesthesia (x3) separate days	01-20-2012
Dr. explanation of necessity letter	01-17-2012
Reconsideration letter for intrathecal medication trial from Dr.	01-04-2012
Progress notes from Dr.	10-28-2011 and 11-22-2011
UR decision (non-certification)	12-15-2011, 01-10-2012

Pre-authorization report from Medical Cost Management	12-15-2011
Appeal letter from Medical Cost Management	05-05-2011, 01-09-2012
Two Copies of the Notice of IRO Decision	06-21-2011
Preauth interspinal morphine trial request	12-12-2011
Progress note from Dr.	10-28-2011, 11-22-2011
Reconsideration Preauth Interspinal Morphine Trial	01-04-2012

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The employee is a male who apparently sustained a work related injury on xx/xx/xx to the low back. He has been seeing Dr. for the pain in the low back and left leg and as of 11-22-2011 had been taking the following medications: Crestor, Warfarin, Aspirin, Promethazine HCl, Lexapro, Baclofen, Morphine sulfate tablets, Ambien, Robaxin, Neurontin and Oxyfast (switched to Oxyfast from the shorter acting morphine because it was not acting fast enough). Dr. notes the functional improvement medications he prescribes allow the employee to do household chores and ADL's. He has undergone lumbar ESI at L5-S1 on 07-10-2002 and at L4-5 on 10-11-2007. Bilateral SI joint injections given 10-2007, 05-22-2008, 04-30-2009 and 01-21-2010 which were reported to give 100%, 80%, 90% and 70% relief for approximately four months.

Imaging studies include:

MRI lumbar on 08-30-2004 showing a central and left sided disc protrusion at L5-S1; L4-5 central disc bulge

MRI lumbar on 02-20-2002 showing prominent disc protrusion at L5-S1 with left S1 NR compression; L4-5 mild central disc bulge

CT lumbar on 07-10-2002 showing L5-S1 annular tear; component of central annular tear at L4-5

Left and right hip x-ray on 12-30-2003 showing mild narrowing superior hip joint

Lumbar x-ray 02-28-2002 showing DDD changes, osteoarthritis

NCV/EMG on 04-06-2005 showing moderate left L5 radiculopathy and mild right S1 radiculopathy.

10-28-2011 Progress note from Dr. stated the medication prescribed provided 70-80% relief. Assessment was back pain (742.2 and 724.5) and radicular pain (729.2). Plan was documented to modify medications to better control pain and referral to Compensation Workers for a request trial for intraspinal morphine.

11-22-2011 Progress note from PA for Dr. stated the pain was worse than it was the prior visit; however the medication still provides 70-80% relief. Assessment was back pain (724.2), lumbosacral radiculopathy (724.4) and sacroilitis (720.2). Plan was documented to order lab work to test for testosterone levels and plasma levels due to the long term use of medications (opioids). WC denying injections- current meds provide adequate analgesia without side effects. Medication continued.

12-12-2011 Preauth interspinal morphine request sent to carrier by Dr. (CPT codes 01992, 77003 and 62311 (x3)) for diagnosis code 724.2, back pain lumbar.

12-15-2011 Preauthorization response from Prium recommending an adverse determination “based on the medical evidence provided, this request has been determined to not be supported for medical necessity”. ODG outlines were used in the determination.

01-04-2012 Letter of reconsideration from Dr. requesting the intrathecal trial for the employee giving clarification on the relief received by the different types of injections the employee had been given. SI joint injections gave relief that lasted only 4-5 months and they did not feel the employee would be a candidate to receive these every 4-5 months. Dr. states the patient gets significant relief with opioids but he has a lot of constipation with the medications despite using OTC stool softeners. Request for psychological evaluation was noted on this letter.

01-09-2012 Appeal letter from recommending an adverse determination based on the ODG criteria not met (“In this individuals case, these criteria are not met. The patient has not yet completed a psychological evaluation”)

01-17-2012 Letter of reconsideration from Dr. with explanation of the request for the intrathecal opioids.

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

One of the criteria of the ODG for the approval of a drug delivery system is a “...psychological evaluation unequivocally states that the pain is not psychological in origin”. In this case, a psychological evaluation has reportedly been requested, but there is no indication that it has been completed. If it has been completed, there is no supplied report. Therefore, the recommendation is for adverse determination as a psychological evaluation that unequivocally states that the pain is not psychological in origin has not been produced. Additionally of note, Warfarin is recorded to be a medication that the patient is taking and anticoagulation is a contraindication to placement of implantable drug-delivery systems per ODG guidelines.

ODG guidelines for implantable drug-delivery systems:

Recommended only as an end-stage treatment alternative in selected cases of chronic intractable pain. This treatment should only be used relatively late in the treatment continuum, when there is little hope for effective management of chronic intractable pain from other therapies. For most patients, it should be used as part of a program to facilitate decreased opioid dependence, restoration of function and return to activity, and not just for pain reduction. The specific criteria in these cases include the failure of at least 6 months of other conservative treatment modalities, intractable pain secondary to a disease state with objective documentation of pathology, further surgical intervention is not indicated, psychological evaluation unequivocally states that the pain is not psychological in origin, and a temporary trial has been successful prior to permanent implantation as defined by a 50-70% reduction in pain and medication use.

**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)