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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 6/14/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of HTRN Eval and 6 HTRN visits intrathecal pump refill/mgmt. (99601/S932). 400 mg Dilaudid IV continuous pain management for 6 months out (J1170). 1200mg Bupivacaine IV continuous pain management for 6 months out (J3490).

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 Internal Medicine. The 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 disagrees with the previous adverse determination regarding the prospective medical necessity of HTRN Eval and 6 HTRN visits intrathecal pump refill/mgmt. (99601/S932). 400 mg Dilaudid IV continuous pain management for 6 months out (J1170). 1200mg Bupivacaine IV continuous pain management for 6 months out (J3490).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: xxxx
xxxx of.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from xxxx xxxxx: 3/16/12 office note from xxxx xxxx.

6/11/12 letter by provider list for case, 4/25/12 denial letter, 5/10/12 denial letter, progress notes from xxxx xxxx xxxx dated 5/18/11 to 4/10/12, 5/31/12 initial FCE report, UR referral sheet 6/7/12, 5/25/11 request for services report, undated treatment plan, 5/3/12 letter from xxx xxxx patient admission assessment 4/13/12, 4/13/12 plan of treatment intra/epidural patients, and low back ODG treatment guidelines for home health services.

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The case involves a male with chronic low back pain from post laminectomy syndrome status post multiple surgeries and injections. His pain is persistent and radiates to both lower extremities. He has an intrathecal pain pump. The injured worker has demonstrated noncompliance with follow up and there are no psychological concerns or concerns about abuse of the analgesic agents.

Request has been issued for home nurse evaluation and 6 home care nursing visits for intrathecal pump management, along with continuous infusion of bupivacaine and Dilaudid.

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

The injured worker has chronic pain status post numerous procedures and there are no other treatment options in this case. There are no psychosocial concerns and there is no contraindication to continue use of the intrathecal pain pump. Home health visits by a skilled nurse are appropriate and most efficient means of service seen the member's intrathecal pain pump, given that he is stable on the pump, not requiring medication adjustments, and there are no concerns about abuse or other psychological issues. Therefore, the requirements set out by the ODG are met. Thus, the requested home nurse assessment and visits, as well as bupivacaine and Dilaudid infusion are medically necessary.

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) Harrison's Principles of Internal Medicine, 18th edition

Milliman Care Guidelines, 16th edition