

US Resolutions Inc.

An Independent Review Organization
3267 Bee Caves Rd, PMB 107-93
Austin, TX 78746
Phone: (361) 226-1976
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/08/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: ASC outpt infusion pain pump trial

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiologist and Pain Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for ASC outpt infusion pain pump trial is not medically necessary for this patient at this time.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Lab studies completed on 06/22/10, 08/10/10, 08/18/10, 04/13/11, 11/17/11, 05/09/12, 02/13/13, & 05/08/13
X-ray of the lumbar spine dated 04/29/08
MRI of the cervical spine dated 05/15/08
MRI of the lumbar spine dated 05/15/08
Clinical notes dated 03/05/08, 04/15/09, 06/22/10, & 07/08/10
Procedural note dated 07/08/10
Clinical notes dated 07/15/10, 08/12/10, 09/09/10, 11/04/10, 12/20/10, 02/14/11, 04/11/11, 06/30/11, & 09/26/11
MRI of the lumbar spine dated 10/28/11
Clinical notes dated 11/14/11, 01/09/12, & 02/06/12
Psychotherapeutic evaluation dated 02/17/12
Clinical notes dated 03/05/12, 04/09/12, 04/13/12, 05/08/12, 05/31/12, & 06/05/12
Required Medical Examination dated 06/07/12
MRI of the lumbar spine dated 06/08/12
Clinical notes dated 07/03/12, 07/31/12, & 08/28/12
Procedural note dated 10/02/12
Clinical notes dated 10/03/12, 10/08/12, 11/19/12, 12/19/12, 01/16/13, 02/13/13, 05/08/13, 07/30/13, & 08/27/13
Psychotherapy evaluation dated 09/16/13
Clinical notes dated 09/24/13 & 10/22/13
Prior certifications from 06/30/10, 03/15/12 & 09/05/12
Adverse determinations dated 09/30/13 & 10/11/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his neck and low back. The clinical note dated 03/05/08 indicates the patient having a past history of left ankle reconstructive surgery in 1981, a left knee surgery in 1982 and again in 2004, as well as a lumbar surgery in 2006. The note indicates the patient having +1 reflexes bilaterally in the upper extremities. Lower extremity reflexes were noted to be absent. Lower extremity strength was graded as 4/5. Hypoesthesia was noted in the left C5, C6, C7, L4, L5, and S1 dermatomes all on the left. The clinical note dated 06/22/10 mentions the patient having complaints of numbness, spasms, and headaches. The patient also reported a sleep disturbance secondary to the pain. The patient rated the pain as 3-9/10.

The procedural note dated 07/08/10 indicates the patient undergoing a bilateral L5-S1 transforaminal epidural steroid injection under fluoroscopic guidance. The clinical note dated 10/20/10 indicates the patient complaining of posterior neck pain radiating to the left shoulder as well as numbness in the left arm. Low back pain was radiating to the left hip. The patient rated the pain as 5/10 at that time. The note indicates the patient smoking 1 pack per day. The clinical note dated 09/26/11 indicates the patient rating his pain as 8/10 which was described as an aching, stabbing, sharp, throbbing sensation with pins and needles. The clinical note dated 02/06/13 indicates the patient continuing with neck and low back pain that was rated as 7/10. The note mentions the patient having undergone physical therapy as well as a home exercise program with no significant benefit. The note indicates the patient having previously been utilizing a TENS unit as well. The clinical note dated 03/05/13 indicates the patient continuing with a burning, aching, pins and needles sensation in the neck and low back. The patient is noted to have previously undergone an L5-S1 laminectomy in 2006. The psychotherapeutic evaluation dated 02/17/12 revealed the patient being an appropriate candidate for a spinal cord stimulator. The Required Medical Examination dated 06/07/12 indicates the patient complaining of localized tenderness at the left of the SI joint. The patient was able to demonstrate 10 degrees of lumbar extension and 45 degrees of bilateral lateral rotation as well as 15 degrees of bilateral lateral bending. The MRI of the lumbar spine dated 06/08/12 revealed a disc protrusion at L3-4 with minor bilateral neuroforaminal stenosis with a possible contact of the exiting right L4 nerve root. Bilateral neuroforaminal stenosis was also noted at L4-5 possibly contacting the exiting L5 nerve root. Laminectomy changes were noted at L5-S1 including minimal enhancing granulation tissue and scarring. The procedural note dated 10/02/12 indicates the patient undergoing a spinal cord stimulator trial. The post-procedural follow up dated 10/03/12 indicates the patient rating his low back pain as 4-6/10. The clinical note dated 12/19/12 indicates the patient continuing with a smoking habit of 1 pack per day. The clinical note dated 02/13/13 indicates the patient reporting lower extremity weakness that was rated as 4-/5 in the right lower extremity and 4/5 in the left lower extremity. The clinical note dated 07/30/13 indicates the patient reported a 50% relief of pain through the spinal cord stimulator trial. The psychology evaluation dated 09/16/13 indicates the patient being recommended for the proposed surgery without the need for psychological treatments. The clinical note dated 09/24/13 indicates the patient continuing with low back pain. The note does indicate the patient having quit smoking. The clinical note dated 10/22/13 indicates the patient continuing with posterior neck and low back pain radiating to the left hip. Numbness was also noted in the left lower extremity.

The prior utilization review dated 09/30/13 resulted in a denial for a pain pump trial as no information was submitted regarding the patient's recent completion of any conservative treatments.

The utilization review dated 10/11/13 resulted in a denial as the patient was noted to have neuropathic related pain resulting in a question of the appropriateness of a spinal cord stimulator instead of an intrathecal drug delivery system. The patient was also noted to be utilizing Aspirin.

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

The patient is noted to have a prolonged history of ongoing neck and low back pain. The patient is being recommended for an intrathecal drug delivery system. However, the patient

was also noted to have undergone a spinal cord stimulator trial which resulted in a 50% reduction in pain. It is unclear as to the reason the patient was not recommended to proceed with a permanent implantation of a spinal cord stimulator. Furthermore, the patient is noted to be utilizing a daily dose of 81mg of Aspirin which is a contraindication to an intrathecal drug delivery system. Given the findings of neuropathic related pain in the low back and taking into account the ongoing use of Aspirin, it is the opinion of this reviewer that the request for ASC outpt infusion pain pump trial is not medically necessary for this patient at this time.

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

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)