

Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (207) 470-1075
Email: manager@becketsystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/28/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Intrathecal pump refill (3 months)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 01/04/12-01/08/13
Pump refill notes 09/12/12-12/26/12
Previous utilization reviews 12/14/12 and 01/03/13
Carrier submission form 01/11/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who previously underwent an intrathecal pump implantation. Clinical note dated 01/04/12 detailed the patient undergoing a pump refill with hydromorphone at 20mg/mL at 13.2mg per day and clonidine 35mcg/mL at 23.1mcg per day. The pump was noted to have 6.5mL recovered with an expected return of 5.5mL at that time. Pain was controlled well with the pump medication. No misuse or diversion was noted. The patient was compliant with the administration through the intrathecal pump as well as all PO medications. The patient utilized Flexeril 10mg every eight hours, Temazepam 15mg at bedtime, and Norco 10/325mg BID. The patient underwent pump refills on 01/25/12 and 02/16/12 and 03/08/12 and 03/29/12 and 04/19/12 and 05/10/12 and 05/31/12 and 06/21/12 and 07/11/12 and 08/01/12 and 08/22/12 and 09/12/12 and 10/24/12 and 11/14/12 and 12/05/12 and 12/26/12 and 01/02/13. The volume recovered at each refill episode exceeded or was at the expected return. Additionally, hydromorphone was increased on 08/01/12 to 13.9mg per day and clonidine was increased to 24.32mcg per day. No significant changes were noted in PO medication administration through the course of each pump refill. The patient's pain level is noted to hover between 5/10 and 9/10. Per clinical note dated 01/08/13, the patient is able to function properly with her medication regimen. The patient reported no side-effects with any of the medications. Per the note, the patient's medications are refilled every 3 weeks. The note details the volume increasing more than anticipated over the previous several refills. However, this was noted to have no decrease in her pain control. No changes in the patient's regimen were

noted.

The previous utilization review dated 12/14/12 resulted in a denial for 3 months of pump refills.

The utilization review dated 01/03/13 resulted in a denial for a pump refill noting that the patient is requesting a refill every 3 weeks whereas guidelines recommend a pump refill every 4-6 weeks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of lumbar region pain. The Official Disability Guidelines recommends periodic refills provided the patient experience an appropriate response to the pain medication. The patient is noted to have regular pump refills every 3 weeks with good response to include a reduction in the patient's pain level. Additionally, the patient is noted to be compliant with the administration as the volume return is noted to be at or near the expected amount. Given the ongoing reduction in the patient's pain level with the ongoing pain pump administration, it is the opinion of the reviewer that this request for Intrathecal pump refill (3 months) is reasonable. As such, the documentation submitted for this review meets guideline recommendations.

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)