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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

O/P ASC Removal of Pain Pump and Intrathecal Catheters

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

Board Certified General Surgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical note 08/07/12

Clinical note 11/07/12

Clinical note 03/06/13

Clinical note 08/15/13

Clinical note 09/19/13

Clinical note 09/12/13

Clinical note 09/26/13

Clinical note 10/16/13

Adverse determinations 10/22/13 and 11/06/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was previously implanted with an intrathecal pain pump. Clinical note dated 08/07/12 indicated the patient presenting for a SynchroMed pump refill. The patient stated that without the pump his VAS level was 10/10 and 5/10 with the pain pump in place. The daily rate of medications by the pain pump remained unchanged. The patient had persistent nausea and vomiting which was addressed with the use of Phenergan. The patient was also utilizing Lortab, soma, Neurontin, Effexor, and promethazine. The patient stated the initial injury occurred when low back pain radiating into the lower extremities. Upon exam strength deficits were noted with dorsi and plantarflexion and in the quadriceps. Sensation was diminished bilaterally in the L4 through S1 dermatomes. Reflexes were absent on the right. Clinical note dated 11/07/12 indicated the patient continuing with low back pain. The patient reported an ongoing reduction in pain with use of the pain pump. The patient was utilizing Dilaudid 20mg/cc and bupivacaine 7.2mg/mL and baclofen at 20 2000mcg to the pump. The patient was utilizing a rate of 2.75mg per day. Clinical note dated 09/13/13 indicated the patient continuing with 5/10 low back pain. The administration

of medications via the pump was reduced by 22% at this time. Clinical note dated 09/12/13 indicated the patient continuing with 5/10 pain. The patient continued with a reduction in pain medication via the pump. Clinical note dated 09/26/13 indicated the patient stating he was feeling much better with a decreasing daily rate. The patient stated he was taking much less Phenergan. The pain pump was reprogrammed to run at a rate of 1.20mg per day. Clinical note dated 10/16/13 indicated the patient requesting removal of pain pump. Pain radiated into the lower extremities. The implantation took place six years prior. Utilization review dated 10/22/13 resulted in denial for pain pump removal as no objective evidence was submitted confirming the need for pump removal. Utilization review dated 11/06/13 resulted in denial as the patient was continuing with significant reduction in pain with use of the pain pump.

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

Clinical documentation indicated the patient having been implanted with an intrathecal pain pump. Pain pump removal would be indicated provided that the patient meets specific criteria, including the pain pump no longer operating properly and causing additional pain. No information was submitted regarding any objective data supporting the need for pain pump removal. Clinical documentation indicated the patient having significant reduction in pain from 10/10 to 5/10 with use of the intrathecal pump. Additionally, a continued reduction in pain was consistent with a reduction in pain medication administration. As such, it is the opinion of this reviewer that the request for a removal of pain pump and intrathecal catheters is not recommended as medically necessary.

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)