

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Mar/21/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** pump interrogation and to reprogram the pump to increase the medication dosage

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Anesthesiology 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 a pump interrogation and to reprogram the pump to increase the medication dosage is not recommended as medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who presented with thoracic region pain. The clinical note dated xxxxx indicates the patient describing the thoracic region pain as intermittent and aching. The note indicates the patient having previously an intrathecal pump implantation in the late xxxxx. A replacement was completed in xxxxx. The note mentions the patient having undergone multiple back surgeries. The patient also had complaints of neck pain that was located in the lower cervical and shoulder region. The patient also had reports of headaches in the right frontal area. The patient described the headaches as a dull and throbbing sensation. The clinical note dated 10/19/11 indicates the patient showing no sign changes in his clinical presentation. However, pain was radiating into the right shoulder from the right side of the neck. The patient described the radiating pain as an aching, chronic, constant, dull, numbness and weakness. The patient also continued to have complaints of low back pain that was described as a dull, sharp, stabbing discomfort with numbness, spasms, and weakness. The patient was utilizing Hydromorphone 20mg per mL via the intrathecal pain pump. The patient underwent the use of 18mL of medications at that time. The pump was refilled with no complications. The clinical note dated 01/11/12 indicates the patient continuing with the intrathecal pump to alleviate the neck and low back pain. The patient stated that the pump medication use was not causing any significant side effects. The patient rated the pain as 4-9/10. The patient continued with the use of Hydromorphone as well as Baclofen via the pain pump. The clinical note dated 10/31/12 indicates the patient continuing with constant low back pain. The patient continued with the use of the intrathecal pump. The clinical note dated 03/13/13 mentions the patient continuing with 4/10 pain in the neck and low back. No dosing changes were identified via the pain pump at that time. The clinical note dated 10/02/13 indicates the

patient having continued thoracic and lumbosacral pain that was non-radiating in nature. The note mentions the patient having medications via pump increased to 3.95mg per day. The clinical note dated 12/18/13 mentions the patient continuing with 4/10 pain despite the ongoing use of the intrathecal pump. The note mentions the patient continuing with the use of Hydromorphone as well as Baclofen. The clinical note dated 02/03/14 mentions the patient being recommended for a pump adjustment. The patient was further recommended for an increase in the pump medications. The clinical note dated 02/18/14 mentions the patient complaining of 7/10 pain in the right neck and lower lumbar region. The patient continued with periodic pump refills. The clinical note dated 02/21/14 mentions the patient being recommended to reprogram the pump to increase the medication dosage.

The utilization review dated 02/10/14 resulted in a denial as there was insufficient clinical information provided to substantiate the requested medication increases.

The utilization review dated 03/05/14 resulted in a denial as insufficient clinical information was submitted to provide support for the request.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient having previously undergone an intrathecal pump implantation with a replacement in 2002. The clinical notes indicate the patient responded appropriately to the use of the current medication regimen. A reprogramming and medication increase would be indicated provided sufficient information is submitted to substantiate the increase in dosage. No information was submitted regarding the specific medication to be increased. There is mention in the clinical note regarding a non-specific 10% increase in the medications. Given that no specific data was included to increase specific medications or to include an additional medication. As such, it is the opinion of this reviewer that the request for a pump interrogation and to reprogram the pump to increase the medication dosage 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

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)