



**Notice of Independent Review Decision - WC**

**DATE OF REVIEW:**

04/16/14

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Morphine Pump Replacement, Revision of Surgery

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

Board Certified in Physical Medicine & Rehabilitation

**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 or not medical necessity exists for each of the health care services in dispute.

Morphine Pump Replacement, Revision of Surgery – OVERTURNED

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The records available for review indicate that the date of injury is listed as xx/xx/xx. It was documented that on the date of injury, the patient sustained a fracture of the left foot. The records available for review indicate that the patient was with a compensable diagnosis of a complex regional pain syndrome referable to the left lower extremity.

It was documented that on 02/01/08, the patient was evaluated. It was documented that the patient had undergone placement of an intrathecal morphine pump on 01/10/08.

It was documented that the patient was with what appeared to be an infection at the operative site. The records available for review indicated that on 02/21/08, the patient underwent explantation of an intrathecal morphine pump.

The records available for review indicated that a replacement intrathecal pump procedure was performed on 10/02/08.

The patient was evaluated on 09/01/08. On that date, the patient was diagnosed with a complex regional pain syndrome of the left lower extremity. The patient was also diagnosed with intractable pain.

A CT scan of the cervical spine, thoracic spine, and lumbar spine was accomplished on 04/20/00. This study showed no findings worrisome for a fracture or a listhesis of the cervical, thoracic, or lumbar regions. There was evidence for spinal stimulator leads that extended to the T8 level of the thoracic spine. There was evidence for subcentimeter lucencies at multiple vertebral bodies at different levels. There was no evidence for any bone erosion or evidence of an aggressive lesion.

The patient was evaluated on 12/15/10. It was recommended that the patient undergo a CT scan/myelogram of the lumbar spine. The patient was with symptoms of low back pain on that date.

A lumbar CT scan/myelogram was accomplished on 02/11/11. This study revealed evidence for the presence of epidural stimulating wires. There was slight dextroscoliosis of the thoracic spine. The report did not describe the presence of a compressive lesion upon a neural element spine.

The patient was evaluated on 02/23/11. On that date, the patient was with symptoms of low back pain with radiation to the lower extremities. It was recommended that a lumbar discogram be accomplished.

evaluated the patient on 05/04/11. On that date, it was documented that a discogram was described as negative. It was felt that the patient was not a surgical candidate with respect to the lumbar spine.

The patient was evaluated on 10/30/12. On that date, it was documented that there were symptoms of low back pain with radiation to the left foot. It was documented that the patient utilized tramadol and Lyrica for management of pain symptoms.

reassessed the patient on 11/20/12. On that date, the patient was capable of ambulating without the assistance of a cane.

An IRO was accomplished on 01/23/13. On that date, it was documented that the patient was entitled to a morphine pump refill as it related to the compensable injury of 11/04/04. It was documented that previous pre-authorization declined approval for a morphine pump refill.

dictated a letter on 03/07/13, at which time it was recommended that the patient receive a neurosurgical consultation. It was documented that there had been an attempt to pursue an intrathecal pump refill, but given the fact that the pump had been off for approximately six months, it was not possible to interrogate the pump and refill the pump.

The patient was evaluated on 04/11/13. On that date, it was felt that the patient was an appropriate candidate for a morphine pump replacement and a revision procedure.

reassessed the patient on 06/06/13 and it was recommended that the patient be considered for treatment in the form of a morphine pump replacement.

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

Based upon the medical documentation currently available for review, the Official Disability Guidelines would support treatment in the form of a morphine pump replacement/revision surgical procedure as reasonable and appropriate. The records available for review indicate that the patient has utilized an intrathecal morphine pump in the past. The records available for review indicate that the patient has requested additional prescription medications to assist with management of pain symptoms because of issues referable to increased pain in the affected lower extremity. As documented in the history, the patient was authorized via TDI Decision and Order to be allowed to have a refill of an intrathecal morphine pump. Given the fact that the pump had been turned off for approximately six months, it was not possible to interrogate the pump and commence utilizing the pump again. As a result, the request for an intrathecal morphine pump replacement/revision procedure would appear medically reasonable and appropriate. Such treatment is considered reasonable and appropriate per the criteria set forth by the Official Disability Guidelines for the management of a medical condition of a complex regional pain syndrome. As a result, in this specific case, after review of the extensive medical records that were submitted for review, this specific request would actually appear medically reasonable and appropriate per the criteria set forth by the Official Disability Guidelines.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**