Date notice sent to all parties: 9/21/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of epidural catheter placement/temporary; inpatient non-surgical room; and fluor GID & LOCLZ NDL/CAT SPI DX/Ther.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Anesthesiology.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of epidural catheter placement/temporary; inpatient non-surgical room; and fluor GID & LOCLZ NDL/CAT SPI DX/Ther.

PATIENT CLINICAL HISTORY [SUMMARY]:
Claimant is a female injured on xx/xx/xx. Claimant was diagnosed with post laminectomy syndrome. She was taking the following medications: amoxicillin, azelastine, soma, clonazepam, cyclobenzaprine, dilaudid, hydrocodone and morphine. MRI of the lumbar spine on 11/22/2011 showed extensive post-operative changes extending from L2-L5. Additionally, there was disc space narrowing with a left, 6mm disc herniation at L1-L2. A right paracentral, 5mm component was present with facet arthropathy that created moderate stenosis with left greater than right sided L2 nerve root compression. Psychological evaluation on 05/25/2015 documented no psychological barriers to an intrathecal pump trial. Depression was present. Evaluation on 06/01/2015 documented back pain with left lower extremity pain.

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

There is no documentation that the current medications have failed to relieve pain and improve function as required per ODG. Additionally, there is no documentation to show that other conservative measures have been attempted without success. Furthermore, there is no documentation to show that further surgical intervention or other treatment such as an ESI is not indicated or likely to be effective. Therefore, the request for an epidural catheter placement with fluoroscopy is not medically necessary.

The Official Disability Guidelines, 19th Edition Low Back Chapter
Used for the treatment of non-malignant (non-cancerous) pain with a duration of greater than 6 months and all of the following criteria are met and documented by treating providers in the medical record:

1. Non-opioid oral medication regimens have been tried and have failed to relieve pain and improve function (see functional improvement); and
2. At least 6 months of other conservative treatment modalities (injection, surgical, psychological or physical), have been ineffective in relieving pain and improving function; and
3. Intractable pain secondary to a disease state with objective documentation of pathology in the medical record (per symptoms, physical examination and diagnostic testing); and
4. Further surgical intervention or other treatment is not indicated or likely to be effective; and
5. Independent psychological evaluation has been obtained and evaluation states that the pain is not primarily psychologic in origin, the patient has realistic expectations and that benefit would occur with implantation despite any psychiatric comorbidity; and
6. No contraindications to implantation exist such as sepsis, spinal infection, anticoagulation or coagulopathy; and
7. There has been documented improvement in pain and function in response to oral opioid medications but intolerable adverse effects preclude their continued use; and
8. A temporary trial spinal (epidural or intrathecal) opiates has been successful prior to permanent implantation as defined by at least a 50-70% reduction in pain and documentation in the medical record of functional improvement and associated reduction in oral pain medication use. A temporary trial of intrathecal (intraspinal) infusion pumps is considered medically necessary only when criteria 1-7 above are met.
9. For average LOS if criteria are met, see Hospital length of stay (LOS).

Intrathecal Pump (icd 86.06 – Insertion of totally implantable infusion pump)
Actual data – median 3 days; mean 5.4 days (0.4); discharges 6,995; charges (mean) $62,325 Best practice target (no complications) – 3 days

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

- ☐ **ACOEM- AMERICAN 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)**