

# IMED, INC.

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07/18/2018

**IRO CASE #:** XXXX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 1 pump refill for intrathecal narcotic pump (XX) ultrasonic guidance of the lumbar spine, as an outpatient

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
MD, Board Certified Anesthesiology

## **REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

## **PATIENT CLINICAL HISTORY [SUMMARY]**

The claimant is a XX XX XX who was injured on XX. The claimant had been followed for chronic pain and post-laminectomy syndrome for the lumbar region. The claimant had an intrathecal pump implanted. The records did not include any recent urine drug screen testing. The claimant's oral medications included XX and XX. The XX clinical report noted complaints of weakness in the lower extremities with numbness. The physical exam noted tenderness to palpation and limited range of motion. There was weakness of the hips and quadriceps. There was diminished sensation in the lower extremities with a positive straight leg raise signs. The requested pump refill was denied by utilization review as there was no clear data showing pain reduction or functional improvement with the use of intrathecal medications.

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

The provided records noted a history of chronic low back pain and a diagnosis of post-laminectomy syndrome. The claimant did have intrathecal medications being prescribed. However, the records did not document the overall efficacy of ongoing use of intrathecal medications in terms of pain relief or functional improvement. Given these issues, it is this reviewer's opinion that medical necessity has not been established and the prior denials are upheld.

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

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN  
ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**