Medical Assessments, Inc.

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May 31, 2018 Amended: June 11, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Intrathecal narcotic pump refill with the increase in dosage

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is Board Certified in the area of Anesthesiology with over 10 years of experience, including Pain Management.

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 XXXX with a history of occupational claim from XXXX. The current documented diagnoses is post laminectomy syndrome and lumbosacral radiculopathy.

XXXX: Office visit by **XXXX**. Claimant complained of low back pain and states that the intrathecal narcotic pump decreases XXXX level of pain to 6/10 on VAS and increases XXXX activity of daily living.

XXXX: Office visit by **XXXX**. Assessment: Lumbar post laminectomy syndrome. Lumbosacral radiculopathy, lumbar region. Claimant reported having unrelieved pain with current treatment despite having XXXX intrathecal morphine pump refilled last month. Lower back pain and bilateral hip pain that radiated down both legs. Pain rated 8/10. PE: The claimant had tenderness to palpation to the spinous process at L4-S1 and the transverse process at L4-S1. The claimant had decreased sensation of the right lower thigh, a positive straight leg raise bilaterally, and a positive Faber's test bilaterally.

XXXX: UR performed by **XXXX**. Rationale for denial: Prior treatment included posterior decompression and pedicle screw placement from L3-L5, medication management, an intrathecal pain pump, and activity modification. Claimant reported having unrelieved pain with current treatment despite having XXXX intrathecal morphine pump refilled last month. The patient was requesting XXXX pump changed to a different medication. However, the documentation submitted for review failed to demonstrate any meaningful improvement in the claimant's symptoms to support a refill of the intrathecal narcotic pump for the claimant. As such, this request is not appropriate for this patient.

XXXX: UR performed by XXXX. Rationale for denial: The previous request was denied as there was not documentation noting efficacy with past medications. Additionally, the treatment plan is for a change in medication but the request is for an increase in dose. Further, the request did not specify requested dosage and the most recent clinical note was dated XXXX. Consequently, the request is not supported. As such, the requested intrathecal narcotic pump refill with increase in dosage is non-certified.

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

Based on the records submitted and peer-reviewed guidelines, this request is non-certified. The previous request was denied as there was not documentation noting efficacy with past medications. Additionally, the treatment plan is for a change in medication but the request is for an increase in dose. Further, the request did not specify requested dosage and the most recent clinical note was dated XXXX. Therefore, the requested intrathecal narcotic pump refill with increase in dosage is non-certified. Therefore, the request for Intrathecal narcotic pump refill with the increase in dosage is found to be not medically necessary.

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)**