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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Pain Pump Trial with XXXX (XXXX)

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

The reviewer is certified by The American Board of Anesthesiology with over 12 years of experience.

REVIEW OUTCOME:

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

☒ Overturned (Disagree)

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]:

XXXX: XX XX-XX WO. Impression- No acute XX pathology. XX changes and postsurgical changes with XX XX.

XXXX: XX XX WO. Impression- No acute XX, XX XX or XX XX.

XXXX: Office Visit with XXXX. Sudden onset of severe XX that is constant. Location is right XX XX, XX XX, XX XX, XX XX and XX. There is XX to XX, XX and XX XX area. This started in the middle of XXXX with pain in the XX XX of XX and XX area, going down XXXX XX and sometimes down the XX with XX and XX into the XX and also across XXXX XX into XXXX XX. XXXX has tried XXXX,without much benefit. XXXX had taken XXXX once a day which has given XXXX some mild relief. XXXX strongly wishes to not take XX.

XXXX: Office Visit with XXXX. Current Medications- XXXX. Patient present with chief complaint of XX pain & XX XX pain. Pain is XX/10. Symptoms as pain with XX, weakness,

XX, XX and XX. Pain is XX, XX, XX, XX and uncomfortable. Moderate pain. Pain XX, only with certain movements. Prolonged sitting, standing, walking, physical activity aggravates the pain. Pt has tried cold activity modification, lying down to relieve the pain/symptoms. Initial treatment consisted of pain management/XX, surgery, brace and anti-inflammatories. Pt has had prior surgery to the painful area. Pt presents today with increased XX pain and XX shoulder pain with decreased motion as XXXX increases activity. XXXX also reports greater XX XX XX times a week. Recently XXXX has experienced about a XX" band of "XX" XX pain radiating down XXXX XX to XXXX XX-XX that lasted only a few minutes but caused pain. XX-XX Exam- XX XX shows decreased XX. The XX has globally XX motion due to XX of the XX XX. No XX tenderness. XX > XX XX tenderness. XX XX Strength. XX, XX, XX XX:5. XX XX: 4. XX Sensation. Reflexes of XX, XX, XX: XX. Hoffman: XX. XX: Pos. XX: XX XX & XX: decreased ROM all planes. XX Motor Strength. Deltoid, Bicep, Brachioradialis, Triceps, Hand Intrinsics: XX. XX Sensation. Reflexes of Bicep, Brachioradialis, Tricep: X+. Hoffman: XX. Lhermitte's: XX. XX: XX. XX: XX tender to palpation & XX joint; Positive XX & XX, XX internal rotation. XX/XX XX XX XX/XX XX-XX on XXXX. XX > XX XX pain; XX XX XX arthroscopy XXXX. Since XXXX continues to have XX XX pain, XXXX is instructed that pain in these areas may be from three different sources: XX XX, XX, &/or XX XX XX. Order XX and XX XX with XX extension x-rays to follow. XX XX XX to XX doc. Take daily NSAID for one month to see if XXXX pain and inflammation are reduced. XXXX.

XXXX: CT XX XX With Contrast. XX XX With Contrast. XX Impression: 1. XX/XX XX and XX XX fusion from XX-XX through XX-XX. 2. Small XX XX XX formation at XX-XX, which mildly XX on the XX XX, mildly XX the XX XX and XX XX. 3. XX XX in the XX fat in the XX XX of the XX at the level of XX, measuring XX.XX.XX.XX CM. XX Impression: 1. XX XX MM XX XX XX extrusion at XX-XX, which impinges on the XX XX and the XX surface of the XX XX XX causing severe XX XX XX XX. 2. XX XX XX disc XX at XX-XX, which impinges on the XX XX and XX surface of the XX XX XX. The XX severely XX the XX XX XX. 3. XX XX XX canal XX XX at XX-XX, which impinges on the XX XX and the XX surface of the XX XX XX causing mild XX XX XX. 4. XX XX XX disc XX at XX-XX, which impinges on the XX XX, contacting the XX XX surface of the XX XX XX. The XX also severely XX the XX XX recess. 5. XX XX XX disc XX at XX-XX, which XX impinges on the XX XX and XX narrows the XX XX and XX XX. 6. Mild XX XX from XX through XX.

XXXX: Office Visit with XXXX. Following XXXX XX surgery, XXXX still has pain in the XX XX XX, which seems to match a XX and possibly XX XX. I do not see anything on the CT XX to correlate this pain. There is no XX on the XX at any level. It is likely that XXXX is having some XX of that XX XX still, despite it being XX. In addition, XXXX is having pain which is XX in XX at XXXX base of XXXX fusion. This correlates well with having XX pain at XX-XX and it is common after a XX fusion down to XX to have XX-XX XX pain. I would recommend XX injections at XX-XX.

XXXX: Office Visit with XXXX. XXXX had a XX injection and due to the injection, this irritated XXXX pain a lot worse. I believe this confirms that XXXX is having some pain from the XX XX, but XX XX relief with the steroid injection into it. The next step I believe would be a XX XX block to see if that alleviates XXXX XX pain and if it does, a XX could be

recommended. Refer back to pain management doc.

XXXX: History and Physical by XXXX. Presents with pain in XXXX XX XX, XX down the XX of the arm, and XX into the XX hand. Occasional XX and XX . Moderate-severe pain. XX/10 at XX and XX/10 at its XX. XX, XX, XX, and XX in nature. Constant. XXXX has tried OTC medications, relative rest, and activity modification without significant improvement. Current Meds- XXXX. XX spine on XX has XX XX tenderness, XX XX points found. Moderate limitation of ROM secondary to pain, no XX, positive XX XX. XX XX and XX test. XX: Reflexes- XX, XX and XX: X+. XX XX. Plan: continue current medications. Recommend XX XX-XX XX to XX joints XX-XX through XX-XX. If good relief, we'll proceed to XX procedure at these levels. Pt continues to use XXXX for pain and inflammation.

XXXX: Office Visit with XXXX. Returns due to recent denial of XX XX-XX. XXXX reports XXXX doesn't feel the XX XX (XX @ XX-XX) provided any significant relief. Typically, a XX is only recommended after good relief from a XX XX. Reviewed the case with XXXX. XXXX agrees that the XX XX Cord XX XX is the best pain alleviating measure at this time. Should the trial reduce the pt's XX pain and XX significantly, the device would be implanted surgically. This would achieve the patient's goal of continuing work without reliance on pain medication.

XXXX: Office Visit with XXXX. XX pain. Pain XX down the XX XX limbs to the XX and fingers XX, XX greater than XX. XX/10 at best, XX/10 at present and XX/10 at worst. XXXX states weakness in the XX XX. Diagnoses: XX XX XX. Pain of XX and XX Region. XX XX. XX Post-XX Syndrome. Pt tried XX XX surgery XX times in XXXX. XXXX also had XX XX arthroscopy. XXXX has had XX shots in the past but states "It didn't really help at all". XXXX had XX XX XX XX-XX. Subsequently there was, according to notes, a request for XX which was denied in XXXX. XXXX saw ortho is XXXX and they suggested a trial of XX XX stimulation. XXXX states physical therapy in the past helped during sessions but no durable relief. XXXX states "I've done so much of it". XXXX states XXXX has done XX or XX sessions of PT in the past few years, including before and after the XX surgery in XXXX. XXXX did PT before and after the XXXX XX surgery. XXXX has tried extensive XXXX but it doesn't really help. Patient tried activity modifications including XX lb lifting restrictions at work. XX XX X-rays sows an XX XX-XX XX XX and fusion. There appears to be spies process wires at XX/XX. Again counseled patient on XXXX, XX, implant. Although pain is XX, the XXXX trial injection is XX because that is where the medication is injected safely into the XX space. If successful trial, the pump implant will be offered. Patient wants to proceed "as long as it's not a XX" in the pump. XX Evaluation done today. Result Summary- XX significant interference in physical treatment is XX as a result of XX, XX, or XX.

XXXX: UR by XXXX. Rationale- According to the guidelines, a trial for implantable drug delivery system is recommended when there is greater than XX months of XX pain when there has been failed non-XX oral medication regimens, at least XX months of conservative treatment to include injections and surgery. Further surgical intervention or other treatment is not indicated or likely to be effective, independent psychological evaluation has been obtained, no contraindications to implantation such as XX, XX infection, XX or XX and documentation of improvement in pain and function in response to oral or good medication but intolerable adverse

effects preclude their continued use. There was no documentation to support improvement in pain and function in response to oral XX medications with intolerable adverse effects precluding their continued use. Denied

XXXX: UR by XXXX. Rationale- ODG recommends implantable drug-delivery systems only when "there has been documented improvement in pain and function in response to oral XX medication but intolerable adverse effects preclude their continued use". In addition, XX therapy with XXXX is recommended only "after there is evidence of a failure of a trial of XXXX." On peer-to-peer, the patient is not noted to have tried first-line XX pain medications such as XX-XX XX XX XX XX XX XX. No medical contraindication to an XX morphine or XX trial was identified beyond a patient preference for a different medication. Denied

XXXX: Letter of Medical Necessity from XXXX. Did a peer-to-peer with XXXX. XXXX asked why we did a XX evaluation rather than face to face XX evaluation. I answered because of a combination of factors, involving us being in a XX area and we had contacted two XX who do not take XX XX and the adjuster then gave the go ahead to do a XX. Patient was denied for no documentation to support failure of conservative treatment with non-XX oral medication regimens and there is no documentation to support improvement in pain and function response to oral XX meds with intolerable adverse effects precluding their continued use. Patient is presently working with restrictions and therefore does NOT want a XX that may cause issues with XXXX employment.

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

The previous adverse decisions are Overturned. Based on the records submitted and peer-reviewed guidelines, this request is certified. ODG recommends implantable drug-delivery systems only when "there has been documented improvement in pain and function in response to oral XX medication but intolerable adverse effects preclude their continued use". In addition, XX therapy with XXXX is recommended only "after there is evidence of a failure of a trial of XX XX or XX." It is reasonable for the patient to be limited in use of oral XX given work restrictions. XX evaluation is acceptable. Therefore, the request for Pain Pump Trial with XXXX (XXXX) is considered medically necessary.
PER ODG XX

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

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☐ **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)**