True Decisions Inc.

Notice of Independent Review Decision

Case Number: XXXX Date of Notice: 7/25/2018 2:29:33 PM CST

True Decisions Inc.

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Notice of Independent Review Decisions

IRO REVIEWER REPORT
Date: 7/25/2018 2:29:33 PM CST
IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Electronic analysis of programmable implanted pain pump, non-inhalation drug for DME, not otherwise classified, XX 220MG, XX, ultrasonic guidance for needle placement

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

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☐ Partially Overtuned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a now XX with a history of an occupational claim from XX. The mechanism of injury is detailed as the patient was XX XX. Prior treatment included medication management, extensive surgery to the lumbar and cervical spine, an intrathecal pain pump, and activity modification. The office visit note on XX, documented the patient complained of low back pain and rated the pain a 6/10 on visual analog scale. The patient reported no change in XX pain and the patient reported functional improvement in XX activities of daily living. XX medications include the XX pump. The patient reported increasing dizziness and decreased oxygen saturation levels due to exacerbation of XX as well as suspected XX infection. The patient's pain pump was refilled and ultrasound guidance was used to facilitate placement. The treatment plan included a random urine drug screen and to follow-up for reevaluation for a pump refill prior to the date of alarm on XX.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
According to the provided documentation, the patient reported continued low back pain and rated the pain a 6/10 on visual analog scale. The patient reported no changes in pain. The patient had a painful range of motion to the head and neck on examination. The submitted request was for painful refill for the dates of service XX and XX. This request was previously denied given the XX clinical record did not identify any specific functional improvement for pain relief

associated with the increase in medication and there was no recent urine drug screen for risk assessment provided for review. There was no additional specific detailed efficacy of intrathecal pump provided to support a return of the previous denial. It was documented that the patient had a 50% improvement in chronic back pain and bilateral leg pain with the use of the intrathecal pump and the patient sleep has improved. The patient was able to stand and walk for longer durations than before the pump was implanted. The patient also reported XX general functioning has improved to include routine activities such as driving and sitting. However, there remains no urine drug screen or risk assessment provided for review documenting no aberrant behavior for this patient with current medications.
As such, the requested Electronic analysis of programmable implanted pain pump, non-inhalation drug for DME, not otherwise classified, XX 220MG, XX, ultrasonic guidance for needle placement is not medically necessary and the review outcome is upheld.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Pain Chapter, Implantable drug-delivery systems (IDDSs)