IMED, Inc

207 E Virginia Suite 208
McKinney, TX 75069
Phone: 214-223-6105 Fax# 469-283-2928
imeddallas@msn.com

9/18/18 and 09/26/2018

Description of the service or services in dispute:
Medical Necessity of a XX.

A description of the qualifications for each physician or other health care provider who reviewed the decision:
Physical Medicine & Rehabilitation; Pain Medicine Physician.

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)

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

Patient clinical history [summary]:

This case involves a now XXXX with a history of an occupational claim from XXXX. The mechanism of injury was detailed as a XXXX. The current diagnoses are documented as status XX, XX, and XX syndrome of the XX region. According to the documentation, the patient had a XX used in combination with oral medications listed as XXXX. The documentation indicates that the patient has 40-50% pain relief with medications. In the clinical note dated XXXX, it was noted that the patient had primary complaint of XX pain. The pain also radiated to the XX region. The patient rated XXXX pain to be a 5/10 in severity. The patient noted some pain relief with rest, lying down, and ice. The pain was worst in the afternoon. It was reported that the patient had 50% relief with pain medication. Upon physical examination, it was reported that the patient had limited range of motion with rotation to the XX and XX. There was tenderness to the XX and XX. Muscle strength and tone are normal in all joints of the XX XX extremities. Sensation was intact as well. The patient was engaged in a XX contract. The treatment plan included continued weakening of XXXX and consideration to a XX stimulator.

Analysis and explanation of the decision include clinical basis, findings, and conclusions

used to support the decision:

According to Official Disability Guidelines, Pain chapter, ongoing use of a pain XX is medically necessary for patients who are clinically stable. According to the documentation the patient has 50% pain relief and is able to maintain activity levels while following a weaning protocol for XXXX. Therefore, the pain XX is medically necessary for this patient. As such, the request for a pain XX is certified.

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

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Pain Chapter, Implantable drug-delivery systems (IDDSs) Recommended only as an end-stage treatment alternative for selected patients for specific conditions indicated in the blue criteria below, after failure of at least 6 months of less invasive methods and following a successful temporary trial. Indications for Implantable drug-delivery systems:

Implantable XX are considered medically necessary when used to deliver drugs for the treatment of:

o Primary liver cancer (intrahepatic artery injection of chemotherapeutic agents);

o Metastatic colorectal cancer where metastases are limited to the liver (intrahepatic artery injection of chemotherapeutic agents);

o Head/neck cancers (intra-arterial injection of chemotherapeutic agents);

o Severe, refractory spasticity of cerebral or spinal cord origin in patients who are unresponsive to or cannot tolerate oral XX (XX®) therapy (intrathecal injection of XX)

Permanently implanted intrathecal (intraspinal) infusion pumps for the administration of opioids or non-opioid analgesics, in the treatment of chronic intractable pain, are considered medically necessary when:

• Used for the treatment of malignant (cancerous) pain and all of the following criteria are met:

(1) Strong opioids or other analgesics in adequate doses, with fixed schedule (not PRN) dosing, have failed to relieve pain or intolerable side effects to systemic opioids or other analgesics have developed; and

(2) Life expectancy is greater than 3 months (less invasive techniques such as external infusion pumps provide comparable pain relief in the short term and are consistent with standard of care); and

(3) Tumor encroachment on the thecal sac has been ruled out by appropriate testing; and

(4) No contraindications to implantation exist such as XX or XX; and

(5) A temporary trial of spinal (XX or XX) opioids has been successful prior to permanent implantation as defined by a 50% reduction in pain. A temporary trial of XX (XX) XX pumps is considered medically necessary only when criteria 1-4 above are met.

• Used for the treatment of non-malignant (non-cancerous) pain with a duration of greater than XX 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, psychologic 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 XX, XX, XX or XX; 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 of XX (XX or XX) opiates has been successful prior to permanent implantation as defined by at least a 50% to 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 (XX) XX pumps is considered medically necessary only when criteria 1-7 above are met.

(9) For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

If treatment is determined to be medically necessary, as with all other treatment modalities, the efficacy and continued need for this intervention and refills should be periodically reassessed and documented.

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**