

August 23, 2007

DATE OF REVIEW: 08/21/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Replacement of remote control for spinal cord stimulator.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., D.O., M.S., Board Certified in Chiropractic, Physical Medicine, Rehabilitation, and Pain Management

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letters of denial and criteria utilized in denial
3. Physician's order and requestor's letter of appeal
4. Treating doctor's most recent office visit note 07/12/07

SUMMARY OF INJURED EMPLOYEE CLINICAL HISTORY:

It appears as though the injured employee sustained an injury to his cervical spine on xx/xx/xx, resulting in a cervical laminectomy, date unknown. He was diagnosed with post laminectomy syndrome of the cervical spine along with brachial neuritis or radiculitis and cervicalgia. He was left with chronic neck pain for which received a dorsal column stimulator. The right side lead of the remote control device utilized to operate the dorsal column stimulator is not working and requires replacement.

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

The Occupational Disability Guidelines set forth the criteria for use of a spinal cord stimulator, which appears to be less of an issue in this case. The spinal cord stimulator has already been implanted. The remote control required to operate the spinal cord stimulator is no longer functional, rendering the spinal cord stimulator of no value.

Based on the assumption that the dorsal column spinal cord stimulator has been appropriately implanted, use of a remote control device to operate the stimulator would appear to be reasonable and, therefore, I believe, appropriate.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 national accepted medical literature (provide a description).
 - Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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