

Clear Resolutions Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW:

JUNE 27, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient revision of dual lead spinal cord stimulator

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

MD Board Certified Orthopedic Surgeon

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office note, Dr. 05/23/03, 04/16/07, 05/15/07, 06/13/07
CT lumbar spine, 12/21/05
Psychological evaluation, 10/16/06

Procedure note, 04/16/07
Utilization review decision, 04/30/07, 05/16/07
Request for IRO, 06/20/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who is status post anterior/posterior fusion, partial facetectomy and laminectomy at L4-5 in October 2002. His current diagnoses include chronic back pain, failed back syndrome and lumbosacral radiculitis. A dual-lead spinal cord stimulator which was placed in January 2004 provided good coverage to his low back and lower extremities until several months ago. The claimant reported inadequate coverage of his lower extremities. Analysis and reprogramming of the neurostimulation system was done on 04/16/07 which resulted in irritative stimulation into the abdomen and inadequate stimulation to the back and legs. Progressive symptoms of radiculopathy with numbness in the left lower extremity were noted. On 05/15/07 the claimant reported painful stimulations into the abdomen leading to decreased use of the stimulator and inadequate pain control with medications. Possible lead migration was diagnosed and a request was made for authorization of revision/replacement of the spinal cord stimulator.

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

The claimant is a male for whom request was made to determine medical necessity of revision of dual lead spinal cord stimulator. Information suggests that this gentleman suffers from post-laminectomy syndrome following a 360 fusion in 10/02. Apparently a spinal cord stimulator was placed in the past. More recently, it has been suggested this gentleman undergo revision of the spinal cord stimulator based on poor coverage.

Unfortunately, the records do not give me a sense as to how this gentleman may have benefited from the previous spinal cord stimulator insertion. In light of the fact that the records don't clearly document quantitative objective signs of meaningful relief following the previous stimulator insertion and as such I cannot recommend the proposed revision of a stimulator as being either reasonable or 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
- Official Disability Guidelines Treatment in Worker's Comp 2007 Updates: Low Back – Spinal Cord Stimulation
- 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)