

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** APRIL 9, 2008

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of proposed percutaneous implantation of neurostimulator electrode array, epidural (63650)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

### **REVIEW OUTCOME**

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

Upheld (Agree)

Overturned

(Disagr

ee)

Partially Overturned (Agree in part/Disagree in part)

| Primary Diagnosis | Service being Denied | Billing Modifier | Type of Review | Units | Date(s) of Service | Amount Billed | Date of Injury | DWC Claim# | IRO Decision |
|-------------------|----------------------|------------------|----------------|-------|--------------------|---------------|----------------|------------|--------------|
| 722.10            | 63650                |                  | Prop           | 1     |                    |               |                |            | Upheld       |
|                   |                      |                  |                |       |                    |               |                |            |              |
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**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a xx-year-old gentleman with a work-related injury on xx/xx/xx. He injured his lumbar spine. The mechanism of injury is not provided. He has been perceived medication management and chiropractic care and has been evaluated by a designated doctor that has not been provided.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC’S POLICIES/GUIDLEINES OR THE NETWORK’S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

The requestor of the IRO does not provide an MRI of the lumbar spine nor are there any documented previous conservative measures of treatment or procedural measures including epidural steroid injections, etc.

Based on the ODG guidelines for neurostimulator neuromodulation include:

1. Failed back surgery, which he has not had.
2. Complex regional pain syndrome, which he does not have.
3. Postamputation pain, which is not documented.
4. Post apractic neuralgia, which is not documented.
5. Spinal cord injury.
6. Dysesthesia.
7. Pain associated with multiple sclerosis, which is not documented.
8. Peripheral vascular disease, which is not documented.
9. Failed interventional pain management, which none are documented or provided by the requestor of the IRO.

For these reasons, this procedure does not meet ODG guidelines due to lack of medical necessity and failure to meet the criteria.

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

- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)