C-IRO, Inc.

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

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 22, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Percutaneous Implantation of Neurostimulator Electrode Array, Epidural

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

MD, Board Certified in Anesthesiology and Pain Management

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.

The reviewer finds that medical necessity does not exist for Percutaneous Implantation of Neurostimulator Electrode Array, Epidural.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/6/08, 8/8/08, 8/15/08
ODG Guidelines and Treatment Guidelines
Letter to IRO from, 9/3/08
PRI, 8/5/08, 8/14/08
PA, 8/22/08, 5/30/08
7/25/08, 6/27/08
Dr. MD, 4/18/08, 3/17/08, 1/22/08
MD, 11/2/06
Lt Hand MRI, 8/4/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient suffers from pain in the left hand and bilateral shoulders. On date of service 06/27/08, a recommendation for spinal cord stimulation was made to help out with the patient's low back and leg pain. However, all of the other notes that were reviewed mention spinal cord stimulation for the upper extremity pain described above. Therefore, there is some confusion as to what is being requested; a thoracic or cervical spinal cord stimulator trial? In addition, on date of service 06/27/08 it is mentioned that the "patient will be referred to a psychologist for an evaluation to determine if the patient is mentally competent for procedure." There has been no documentation showing that the patient has undergone a psychological evaluation.

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

Per the Official Disability Guidelines, a psychological evaluation is "recommended pre-spinal cord stimulator trial." Since this has not been performed yet, a spinal cord stimulator trial would not be appropriate at this time. In addition, as stated above, there needs to be clarification as to which pain is being treated, low back pain or upper extremity pain. The reviewer finds that medical necessity does not exist for Percutaneous Implantation of Neurostimulator Electrode Array, Epidural.

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**
- ☐ **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)**