



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

#### *MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 01/06/2009**

**IRO CASE #:**

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

Percutaneous implantation/leads and programming trial (lumbar spinal cord stimulator trial) with anesthesia and fluoroscopic guidance

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management 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 or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Texas Dept of Insurance Assignment to 12/22/2008
2. Texas Dept of Insurance notice of assignment of IRO 12/22/2008
3. Confirmation of Receipt of a Request for a Review by an IRO 04/11/2008
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 01/04/2008
6. Pain Institute note 04/21/2008
7. Progress note 01/15/2008
8. Pain Institute note 12/24/2007
9. post appeal review 12/05/2007
10. physician review 12/05/2007
11. Pain Institute note 11/29/2007, 11/27/2007
12. peer reviewer triggered letter 11/21/2007
13. physician review 11/21/2007
14. Clinical and Rehabilitation Psychology note 11/14/2007
15. Pain Institute note 10/31/2007
16. Progress note 08/27/2007, 08/06/2007
17. Pain Institute note 04/18/2007, 01/04/2007
18. The Clinic note 12/18/2006, 11/08/2006, 10/16/2006, 09/27/2006



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19. Nydic medical imaging 12/04/2005
20. ODG guidelines were not provided by the URA

### **PATIENT CLINICAL HISTORY:**

The patient is a xx -year-old male with injury on xx/xx/xx, when he slipped and fell. The diagnosis is chronic low back pain. Patient is status post treatment with physical therapy, medication, and epidural steroid injections. The patient has been on Ultram, Cymbalta, Flexeril, and hydrocodone. MRI shows a grade 1 spondylolisthesis at L5-S1 with degenerative changes with neural foraminal stenosis.

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

The patient has not had any previous surgery documented in the records. The Official Disability Guidelines indications for spinal cord stimulator implantation, which includes is failed back surgery syndrome, and persistent pain in patients who have undergone at least one previous back operation. Therefore, the patient does not meet the guideline criteria by the Official Disability Guidelines and at this point is denied.

### **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 KNOWLEDGBASE
- 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)