



Medwork Independent Review

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DATE OF REVIEW: 07/16/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal Cord Stimulator Trial (Single Lead)

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.

PATIENT CLINICAL HISTORY:

The patient slipped and fell in xxxx, and since that time has had chronic leg pain. The patient has had knee surgery with subsequent reflex sympathetic dystrophy of the lower extremities. The patient still has pain in that extremity that is burning and aching in nature that is 8 on a scale of 0-10. On physical exam, there is decreased range of motion and stiffness in that leg. Patient has tried a TENS unit and epidural steroid injections. Medications consist of Norco, tramadol, Valium, and Xanax. Patient had a lumbar sympathetic block that was diagnostically positive for reflex sympathetic dystrophy. The patient also has a psychological assessment on the chart, which clearly states that the patient has no problems and no contraindications for a spinal cord stimulator trial. The question now is if a spinal cord stimulator trial medically necessary.

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

Referring to the Official Disability Guidelines' chapter on pain where it clearly states that spinal cord stimulator trials can be used for patients with reflex sympathetic dystrophy and a psychological assessment should be on the chart for those types of patients, and this is. Therefore, this should be approved.

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



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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)