

SENT VIA EMAIL OR FAX ON
Mar/17/2009

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

electode placement neurostimulators (spinal), removal electrode percutaneous neurostimulators, programming, patient trial kit model, precision linear contact lead 50cm, monitored anesthesia care under fluoroscopy

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 11/3/08 and 11/18/08
Record from Dr. 12/6/08
CT Lumbar Spine 3/31/05
Behavioral Eval 10/21/08
Health Systems 11/5/08
Record from Dr. 1/5/09

PATIENT CLINICAL HISTORY SUMMARY

This man was injured on xx/xx/xx. He underwent a spinal fusion in 2002 and had ongoing back pain and right leg pain. Dr. performed an IME in 2005 and noted in the 2008 note that

he had problems at L3-4. Surgical removal of the hardware was considered. The previously treating surgeons were no longer involved in his care. Apparently no one would accept responsibility for the removal of the hardware. Dr. saw him in January 2009 and had reservations about any hardware removal. He was felt to have post laminectomy syndrome. He had a psychological assessment in October 2008 by an LPC, who felt there were no psychological contraindications to a spinal stimulator.

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

A key reason for prior denial of the spinal cord stimulator was the likelihood of having additional spinal surgery and removal of the hardware. The ODG recognizes that the SCS is appropriate at time in the treatment of failed back syndrome. In fact, it can be a better alternative than additional surgery. Since it is unlikely that additional spinal surgery will be performed based upon the reports in the record, and then the use of the stimulator is justified.

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)