

SENT VIA EMAIL OR FAX ON
Nov/09/2009

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/08/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Psychological Eval for possible lumbar spinal cord stimulator trial.

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 10/5/09 and 10/12/09
Dr. 7/14/09 thru 9/24/09
Radiology Report 8/10/05 thru 5/22/08
Clinic for Pain 5/22/09

PATIENT CLINICAL HISTORY SUMMARY

This man has bilateral low pain and numbness with weakness. Apparently nothing helps. He may have had recent MBB. There is a request, but the Reviewer could not determine if there were any more recent than those in 2008. The records describe a lumbar laminectomy and fusion. He apparently had a spinal stimulator removed in 2007, but the Reviewer could not determine when it was inserted, if it helped or why it was removed. There is a comment in the 7/14/09 note for psychological assessment for a chronic pain program. He had multiple

MRIS. The most recent in 5/08 showed the hardware from the fusion, post op changes at L5/S1 and a disc bulge at L4/5. The one in 9/06 showed epidural fibrosis on the bilateral S1 roots. Electrodiagnostic studies showed a sensory neuropathy. There are prior denials for trigger point injections.

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

Before considering him for a psychological assessment for a spinal cord stimulator, the Reviewer needs to know why the prior one was removed. While psychological assessment before the implantation of a spinal stimulator would be justified, the Reviewer saw nothing in the record suggesting this was underway. As noted, there was a comment, and not a request, for possible psychological assessment for a chronic pain program. That was not requested.

ODG:

Spinal cord stimulators (SCS) Pain

Recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions indicated below, and following a successful temporary trial. Although there is limited evidence in favor of Spinal Cord Stimulators (SCS) for Failed Back Surgery Syndrome (FBSS)

This individually based observational evidence should be used to demonstrate effectiveness and to determine appropriate subsequent treatment.

SCS for treatment of failed back surgery syndrome (FBSS) reported better effectiveness compared to reoperation ([North, 2005](#)).

Indications for stimulator implantation:

- Failed back syndrome (persistent pain in patients who have undergone at least one previous back operation and are not candidates for repeat surgery), when all of the following are present: (1) symptoms are primarily lower extremity radicular pain; there has been limited response to non-interventional care (e.g. neuroleptic agents, analgesics, injections, physical therapy, etc.); (2) psychological clearance indicates realistic expectations and clearance for the procedure

Psychological evaluations, IDDS & SCS (intrathecal drug delivery systems & spinal cord stimulators)

Recommended pre intrathecal drug delivery systems (IDDS) and spinal cord stimulator (SCS) trial. See the [Stress & Mental Conditions Chapter](#)

Patient's who have a history of failed surgery

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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