



Southwestern Forensic  
Associates, Inc.

**DATE OF REVIEW:** 09/15/09

**IRO CASE #:**

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

Replacement of spinal cord stimulator generator

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

The medical necessity for replacement of the generator has not been established.

**INFORMATION PROVIDED FOR REVIEW:**

1. TDI Referral
2. URA notes, 7/17/09 to 7/29/09
3. Ph.D., Behavioral Assessment, 6/25/09
4. MD, office notes, 10/4/2004 to 5/7/2009

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This individual was injured in xxxx and has neck and thoracic pain with a diagnosis of reflex sympathetic dystrophy. A spinal cord stimulator has been implanted in the past. The generator is at end of life, and the request is for replacement of the generator and repositioning of the lead.

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

The ODG criteria states that at least 50% pain relief should occur to warrant spinal cord stimulator modality. There is no documentation of degree of efficacy of the stimulator modality. Therefore it is not reasonable to replace the generator.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

*(Check any of the following that were used in the course of your review.)*

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)