

SENT VIA EMAIL OR FAX ON
Sep/21/2009

Applied Assessments LLC

An Independent Review Organization

1124 N Fielder Rd, #179

Arlington, TX 76012

Phone: (512) 772-1863

Fax: (512) 857-1245

Email: manager@applied-assessments.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/16/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Permanent Implant Spinal Cord Stim Octode Leads, IV Sedation, Fluoro

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 6/30/09, 7/14/09, 7/24/09

OP Report 6/18/09 and 6/22/09

Psych Eval 5/11/09

Center for Pain Relief 10/14/08 thru 8/3/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man who fell on xx/xx/xx. He developed knee pain. He had multiple treatments, which included a total knee replacement. He was diagnosed with CRPS=I/RSD. He also has PTSD, depression and prostate cancer. Dr. completed a psychological assessment. He found no contraindication to the procedure. A trial stimulator was inserted on 6/18/09 and removed on 6/22/09. It provided 85% reduction in pain.

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

This man has RSD. He responded to the trial stimulator. There are no psychological contraindications reported. The Reviewer is not sure where the prior prostate cancer would contraindicate the implant, other than it may make it difficult to use MRIs to observe for possible metastases. This needs to be weighed against immediate pain relief. While there was no documented reduction in the amount of pain medication used, this is not necessarily the sole criteria over a 3 day trial. He did describe significant pain relief. Therefore, the request is medically necessary.

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)