

SENT VIA EMAIL OR FAX ON
May/11/2010

True Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 276-1904
Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/03/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Spinal Cord stimulator explant under fluoro with anesthesia

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 2/26/10 and 3/16/10
Carrier Submission 4/26/10
Letter from Patient 4/29/10
Hospital 3/1/04
Cervical Myelogram 3/5/03
Diagnostics 4/14/04 and 8/17/04
Medication List 3/5/10
Dr. 11/09/04
Dr. 11/1/04 thru 10/12/09
Dr. 8/1/05
Group Associates 1/4/05

Dr. 12/11/03 thru 1/20/05
Pain 8/19/03 thru 9/13/04
OP Report 11/30/09, 11/16/09, 10/30/09, 9/8/05, 11/3/05
Dr. 5/3/05 thru 3/5/10
Dr. 5/3/05 thru 3/5/10

PATIENT CLINICAL HISTORY SUMMARY

This man was injured in xxxx. He underwent multiple cervical operations including a failed fusion. He was evaluated in 2005 for a spinal stimulator. Dr., in 2005, felt that he was a "fair candidate at best for a stimulator." This less than ringing endorsement was followed by the insertion of the stimulator in 2005. It did not work. Dr. noted the preexisting psychological issues and personality issues and wrote against the insertion of the stimulator before and after its insertion. Dr. wrote in "If the stimulator is non-functioning or not providing the pain relief expected and as the claimant still requires the use of oral medications, then removal of the spinal stimulator would be appropriate." He further wrote that this should not be done under workers comp as it was not approved in workers comp. This report by Dr. is missing the dated page. The last note reviewed was from Dr. in 8/09 which means this review occurred sometime in the past 9 months. There are several notes from Dr. on why the device should be removed due to pain at the battery and anchoring sites.

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

The IRO reviewer is not sure that there are any specific guidelines in the ODG that are fully applicable about the removal of the device. It is obvious that it was inappropriate to have been implanted. Dr. agrees it should be removed, but does not think the Workers Comp carrier should pay. His logic is that they did not pay to install it. Mr., the patient wrote to this point. He stated that the device was put in at Workers Comp payment. He said that Dr. implanted it.

However, the IRO is to determine if there is a medical necessity for its removal. It is possible to live with it in place. There are surgical risks with its removal. The psychological issues (even if preexisting) suggest, and Dr. agrees, that the device should be removed. 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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