

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: October 27, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Transcranial Magnetic Stimulation; 10-22-09

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

GENERAL AND FORENSIC PSYCHIATRIST
BOARD CERTIFIED BY THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

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

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- Texas Department of Insurance, 10/11/10
- 03/09/10
- M.D., 05/07/10, 06/24/10
- Behavioral Health, Inc., 07/21/10, 07/27/10
- Case Notes, 06/08/10, 06/14/10, 06/15/10, 07/21/10
- Request for a Review by an Independent Review Organization, 08/27/10
- 09/21/10
- Department of Health & Human Services, 10/07/08

Medical records from the Provider include:

- Psychiatric Associates, 08/04/09, 03/02/10

PATIENT CLINICAL HISTORY:

The review outcome is upheld.

The patient is a male with chronic/recurrent depression which has been partially responsive to medications.

The patient was seen for a consultation for transcranial magnetic stimulation on August 4, 2009. This was recommended.

There is only one additional treatment note from March 2, 2010, which indicates the patient may have had hypomanic episodes with antidepressants which raise the possibility of him having an atypical bipolar disorder.

The patient reportedly received transcranial magnetic stimulation from October of 2009 through November of 2009. The results and the details of those treatments are not included in the submitted documentation.

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

I reviewed the articles submitted by the provider. I reviewed the CIGNA Medical Necessity Criteria. I also compared their criteria with a number of other major health care policies, as well as their rationale for considering transcranial magnetic stimulation an experimental procedure, including Aetna and Blue Cross/Blue Shield, with the most recent review by Aetna in their Clinical Policy Bulletin: Transcranial Magnetic Stimulation and Cranial Electrical Stimulation, which was reviewed on August 3, 2010. While transcranial magnetic stimulation holds some promise of treatment-resistant depression, there are a number of unknowns with it to the degree that overall the treatments are still considered experimental and investigational.

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

- 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 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 (MULTIPLE ARTICLE SUBMITTED BY THE REQUESTOR AND MEDICAL NECESSITY CRITERIA BY CIGNA, AETNA AND BLUE CROSS BLUE SHIELD)