

Wren Systems

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Sep/01/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Spinal Cord Stimulator Trial (77003 FLUOROGUIDE FOR SPINE INJECT; L8680 Implt neurostim elctr each; 63650 IMPLANT NEUROELECTRODES; 00620 ANESTH SPINE CORD SURGERY)

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

M.D., Board Certified in Anesthesiology and Pain Management

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

ODG

Adverse Determination Letters, 7/15/10, 8/2/10

D.O. 8/2/10

M.D. 7/15/10

4/29/10, 4/21/10, 4/14/10, 7/22/10

M.D. 3/12/09

12/2/09

7/15/10

6/2/10

PATIENT CLINICAL HISTORY SUMMARY

Per the 4/29/10 OV note, this patient complains of "low back pain, bilateral hip, buttock and leg pain." The patient has failed "physical therapy, TENS, epidural steroid injections, heating pad, massage, ice, medications, exercise, and chiropractic." In addition, the patient has a history of a L4-S1 fusion. The patient was evaluated by a Dr., a psychologist, on 6/2/10. According to the notes, Dr. considers the patient "clear for the stimulator, with a good prognosis for pain reduction and functional improvement."

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

Per the ODG, one of the indications for stimulator implantation is as follows: "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; (3) there is no current evidence of substance abuse issues; (4) there are no contraindications to a trial." This patient meets all of these criteria and is therefore a candidate for a SCS trial. The reviewer finds that medical necessity exists for Spinal Cord Stimulator Trial (77003 FLUOROGUIDE FOR SPINE INJECT; L8680 Implt neurostim elctr

each; 63650 IMPLANT NEUROELECTRODES; 00620 ANESTH SPINE CORD 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)