

Notice of Independent Review Decision  
**IRO REVIEWER REPORT**

DATE OF REVIEW: 03/30/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Permanent Lumbar Spinal Cord Stimulator with Dual Leads

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

The TMF physician reviewer is board certified in anesthesiology and pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the permanent lumbar spinal cord stimulator with dual leads is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 03/17/XX
- Letter of Determination– 10/14/XX, 12/03/XX, 01/10/XX, 01/19/XX, 12/03/XX
- Request for preauthorization by Dr.– 11/30/XX, 01/10/XX
- Worker's Compensation Form – 12/23/XX
- Office visit notes by Dr.– 08/12/XX to 03/15/XX
- Decision letter– 12/03/XX
- Discharge Summary from Dr.– 11/16/XX
- Procedure note by Dr.– 11/16/XX
- Secured message– 10/29/XX
- Psychological Evaluation by Dr.– 09/17/XX
- PEER Review from Dr.– 10/09/XX
- Medical Review by Dr.– 01/21/XX
- Report of x-rays of the lumbar spine – 02/11/XX
- Report of MRI of the cervical, thoracic and lumbar spine – 10/08/XX
- Report of MRI of the lumbar spine – 04/21/XX, 01/31/XX, 08/29/XX

- Report of MRI of the cervical spine – 06/27/XX
- Followup office visit notes by Dr.– 09/15/XX
- Consultation by Dr.– 03/12/XX

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on XX/XX/XX when she tripped and fell onto her buttock. This resulted in injury to her lower back. The patient had complaints of cervical as well as lumbar pain. She has undergone a trial with spinal cord stimulation on 11/16/XX and there is a request from the treating physician for a Permanent Lumbar Spinal Cord Stimulator with Dual Leads.

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

This patient has bilateral neuropathic pain to the lower extremities which responded extremely well to a trial stimulator. Pain reduction of greater than 50% is considered a successful trial and this patient had over 80% pain reduction. She had at least one lumbar spinal surgery which failed to control her pain. The patient wishes to proceed to a permanent stimulator and has undergone psychological clearance. The treatment with a trial of the stimulator matches the ODG guidelines except the patient had significantly greater reduction in pain than the ODG guidelines and suggests the necessity for proceeding to the implantation of a permanent stimulator. This patient has failed conservative care, has had psychological clearance and a successful trial with a spinal cord stimulator. Essentially the ODG guidelines fully support this type of treatment which justifies the implantation of a permanent lumbar spinal cord stimulator.

**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 (PROVIDE A DESCRIPTION)