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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L8689, external battery recharging system

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

M.D., Board Certified Anesthesiology/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

Official Disability Guidelines

Denial letters, 11/03/11, 10/18/11

Emergency physician records 11/04/02, 02/22/03, 05/07/03, 05/12/03, 05/14/03, 05/30/03, 06/05/03, 06/14/03, 06/07/03, 06/22/03, 06/25/03, 07/03/03, 07/06/03, 07/11/03, 07/12/03, 07/20/03, 07/24/03, 07/27/03, 08/02/03, 10/18/03, 11/07/03, 12/14/03, 12/19/03, 12/27/03, 01/07/04, 08/06/04, 08/09/04, 10/08/04, 10/09/04, 10/24/04, 11/12/04, 11/26/04, 12/06/04, 12/18/04, 02/04/05, 04/03/05, 04/23/05, 05/06/05, 05/22/05, 03/07/05

MRI left hip 05/24/05

HealthSouth testing report 05/31/05

Follow up note dated 06/08/05, 09/12/05, 10/06/05, 11/14/05, 12/12/05, 01/12/06, 02/09/06, 03/09/06, 04/07/06, 05/04/06, 06/01/06, 08/07/06, 08/24/06, 09/07/06, 09/27/06, 10/04/06, 11/20/06, 12/06/06, 01/22/07, 02/14/07, 03/08/07, 03/30/07, 04/05/07, 04/12/07, 04/11/07, 04/27/07, 05/17/07, 05/24/07, 06/15/07, 06/20/07, 08/22/07, 09/05/07, 09/12/07, 09/19/07, 10/15/07, 12/14/07, 01/07/08, 02/14/08, 04/10/08, 06/05/08, 06/09/08, 07/07/08, 08/07/08, 09/04/08, 10/30/08, 12/04/08, 12/19/08, 12/29/08, 01/07/09, 02/27/09, 03/11/09, 03/13/09, 04/13/09, 04/15/09, 04/30/09, 05/06/09, 05/29/09, 06/03/09, 06/29/09, 08/27/09, 09/16/09, 10/07/09, 10/29/09, 12/02/09, 12/28/09, 02/03/10, 02/26/10, 03/31/10, 07/21/10, 04/23/10, 04/27/10, 05/26/10, 08/24/10, 10/21/10, 10/18/11, 09/29/11, 07/19/11, 01/20/11, 04/21/11

Independent medical examination 06/24/10

Laboratory report 09/21/07, 10/29/09, 10/21/10

Peer review 07/11/07, 07/09/08

Functional capacity evaluation 05/18/07

Consultation 02/15/07

Program daily report 03/13/07, 03/05/07, 03/06/07, 03/14/07, 03/07/07, 03/08/07, 03/09/07,

03/12/07, 03/15/07, 03/16/07, 04/04/07, 04/05/07, 04/09/07, 04/10/07, 04/11/07, 04/12/07,
04/16/07, 05/14/07, 05/15/07, 05/16/07, 05/17/07
Electrodiagnostic medicine consultation 09/29/06
Chronic pain evaluation 03/01/06, 01/10/07
Neurosurgical consultation 05/04/05
Radiographic report 05/04/05, 12/18/08
Lumbosacral CT myelogram 08/05/03
Addendum to RME 08/14/03
Required medical examination 07/08/03, 08/23/04, 06/20/05, 11/04/06
Handwritten notes 06/16/03-06/19/03, 08/11/03, 04/14/05-05/12/05, 06/20/05-06/23/05,
08/24/05-08/25/05, 10/19/05-10/24/05, 01/28/06-06/20/06, 09/14/06-12/06/06, 01/08/07,
02/05/07, 04/02/07, 03/06/07, 03/30/07, 04/30/07, 05/31/07, 07/02/07, 08/30/07, 09/12/07,
08/21/07, 06/12/08, 02/18/09, 05/20/09, 11/04/09, 12/16/09, 02/17/10, 04/14/10, 06/08/10,
08/09/10, 05/26/10
Letters 05/31/07, 10/18/11
Daily progress notes 04/03/07, 04/09/07, 04/16/07, 05/14/07, 05/16/07
Office visit note 08/13/03, 07/07/05
Medical records review 02/05/03
Designated doctor evaluation 11/21/03, 03/29/04, 07/29/05
Procedure note 08/15/05, 10/31/05, 09/20/06, 11/13/06, 05/06/09, 04/27/10, 06/14/11
Checklist dated 09/20/06
Post anesthesia recovery record 09/20/06

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female who was injured on xx/xx/xx. She was injured when she was helping a when she fell. She injured her low back, and had a contusion to the sacrum and coccyx. Peer review dated 02/05/03 stated that she has at best a soft tissue injury, i.e., a contusion with ongoing complaints of pain. The patient should have reached MMI as of 02/02/03. The patient underwent 3 injections between February and May 2003, which produced no results. RME dated 07/08/03 indicates that the patient underwent knee surgery four days after the date of injury and underwent a course of postoperative physical therapy. CT myelogram dated 08/05/03 was reported as a negative study. The patient presented to the emergency department on several different occasions (at least 18). RME addendum dated 08/14/03 indicates that there is an absence of any identified pathology and the presence of rather dramatic pain complaints. Designated doctor evaluation dated 03/29/04 indicates that the patient reached MMI as of this date with 5% whole person impairment. RME dated 08/23/04 indicates that the left L5 nerve root/sciatic irritation is directly the result of the xx/xx/xx injury. RME dated 06/20/05 indicates that there is no objective evidence to substantiate that the patient has a left L5 nerve root irritation or piriformis syndrome as an explanation for either the magnitude or perpetuation of her asserted somatic complaints or her purported level of disability. Designated doctor evaluation dated 07/29/05 indicates that the patient reached MMI as of 11/21/03 with 6% whole person impairment. The patient underwent left sciatic nerve block and piriformis muscle injection on 08/15/05 and reported significant improvement for 1 ½ weeks. The patient underwent lumbar transforaminal epidural steroid injection left L5-S1 on 10/31/05 without any significant relief. The patient underwent spinal cord stimulator trial on 09/20/06 with subsequent implantation on 11/13/06. Follow up note dated 12/06/06 indicates that the patient reports 50% decreased pain. Follow up note dated 01/22/07 indicates that the patient was involved in a motor vehicle accident about a month ago. There was no migration of her spinal cord stimulator lead, but she noticed that she is not having good coverage of her lower mid back pain. The patient underwent a chronic pain management program in 2007. RME dated 07/11/07 indicates that medical documentation has never demonstrated an objective basis for the complaints of back pain and left leg pain. Follow up note dated 08/22/07 indicates that the spinal cord stimulator is providing her with pain relief that is beneficial, but she did sustain a fall a couple of weeks ago. This has not affected her pattern of stimulation. Note dated 04/10/08 indicates that the stimulator allows her to walk longer distance and she has increased her activities significantly. The patient underwent left trochanteric bursa injection on 12/19/08, 05/06/09 and 10/07/09 with excellent results. IME dated 06/24/10 indicates that the patient presents with a chronic pain syndrome that has been treated with a dorsal column stimulator with only partial relief. It is difficult to

explain this injury on an objective basis. It appears that she has increasing escalation of pain medication but we do not see increases in clinical function or reduction of pain levels. The patient reports that she only gets out of bed approximately 5 days a month. The patient has subjective complaints that have never been verified with objective findings. One would have expected her complaints to resolve a long time ago, but she continues to have chronic pain. Follow up note dated 01/20/11 indicates that the stimulator continues to provide adequate stimulation. The patient underwent left greater trochanteric bursa injection on 06/14/11. Follow up note dated 09/29/11 indicates that the patient reports approximately two weeks ago she was having difficulty charging her unit and thinks she has a problem with the generator or the charger. She has not been able to use her stimulator recently due to the difficulty with charging and has to use more Hydrocodone for breakthrough pain. Note dated 10/18/11 indicates that Boston Scientific technician has checked the unit and generator is working effectively. However, the patient is having difficulty with the charging unit as well as the remote and this is what they are requesting that be replaced.

Initial request for external battery recharging system was non-certified on 10/18/11 noting that there is no clear documentation of a condition/diagnosis for which spinal cord stimulator is indicated. Therefore, the medical necessity of the request has not been substantiated. The denial was upheld on appeal dated 11/03/11 noting that clinic notes do not indicate if the generator and the charging unit are malfunctioning.

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

The patient underwent spinal cord stimulator placement in 2006 and recently noted that she is having difficulty charging her unit. Serial medical record reviews have documented that there is no objective evidence to substantiate that the patient has a left L5 nerve root irritation or piriformis syndrome as an explanation for either the magnitude or perpetuation of her asserted somatic complaints or her purported level of disability. It is difficult to explain this injury on an objective basis, and the patient has subjective complaints that have never been verified with objective findings. Given that the patient does not present with any of the conditions for which spinal cord stimulator is supported by the Official Disability Guidelines, the reviewer finds the requested L8689, external battery recharging system is not medically necessary. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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)