

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OUTPT SCS Trial W 2 leads 63650 under anesthesia w/fluor guidance

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

M.D., Board Certified Orthopedic Surgeon
Board Certified Spine Surgeon

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

11/19/10, 12/15/10

M.D. 7/21/10 to 1/6/11

Ph.D. 11/5/10

Chiropractic Clinic, Inc. 1/26/10 to 4/16/10

M.D. 7/22/08 to 10/21/09

Impairment Summary 3/25/04 to 3/31/04

Conroe 7/31/07

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who underwent a lumbar spine fusion at three levels in xxxx. He had hardware removal in 1999. He complains of back pain with no radiculopathy. There is no evidence of any neurological deficit on multiple physical examinations from multiple providers. The medical records indicate that the spinal cord stimulator in this case is being recommended for back pain.

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

Based upon the Official Disability Guidelines, the use of spinal cord stimulator is for patients who have primarily lower extremity radicular symptoms. In this case, this patient does not have predominantly lower extremity radicular symptoms but rather nonradicular back pain. He does not meet the Official Disability Guidelines and Treatment Guidelines criteria for a

spinal cord stimulator. It is for this reason the previous adverse determination could not be overturned. The treating physician does not explain why the ODG should be set aside in this particular case. The reviewer finds no medical necessity for OUTPT SCS Trial W 2 leads 63650 under anesthesia w/fluor guidance.

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)