

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 18, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed spinal cord stimulator trial with fluoroscopy and MAC anesthesia

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
Unk	spinal cord stimulator trial with fluoroscopy and MAC anesthesia		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The records presented for review begin with a note from, PA-C. She is requesting reconsideration of the trial for spinal cord stimulator. The next note is the determination of non-certification completed by Dr.. The notes reflect that this was a knee injury that two separate arthroscopic procedures had been attempted, and that treatment included a total knee arthroplasty. The current working diagnosis is "reflex sympathetic dystrophy." Dr. also noted that the imaging studies suggest a possible loosening of the prosthetic device or a possible infection. Weakness was noted; however, there is no evidence of sensory changes. The reason for the non-certification would appear to be that the standards identified in the official disability guidelines had not been met. The determination of a diagnosis of Reflex Sympathetic Dystrophy was outlined and that the two separate diagnoses of loosening of the prosthetic device and osteomyelitis had not been clarified. The prior non-certification from Dr. is also reviewed. A specific discussion as to why this was not certified is outlined noting the claimant to be morbidly obese (254 pounds) and that the diagnoses that would be addressed by this device were not objectified.

I did note the progress note from Dr. dating back to August 2010. It was noted that this injury dates back to xx/xx/xx. The pain and swelling at night is reported, the non-pharmacologic approaches that have been played are noted, The findings noted on imaging studies are reviewed. Without any evidence to support the assessment, a diagnosis of sympathetic dystrophy of the lower extremity is made.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

As noted in the Division mandated Official Disability Guidelines the requirements for a spinal cord stimulator are specific. As noted by both reviewers, none of these requirements have been met. There is no objectification of a CHRONIC REGIONAL PAIN SYNDROME or failed low back. Further, with the suspicion of a possible lucency/lytic area in the medial part of the proximal left tibia that may be due to loosening or possible infection, these need to be evaluated prior to pursuing this type of device. Therefore, the URA denial is upheld as medical necessity could not be established.

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

- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES