

SENT VIA EMAIL OR FAX
ON Jan/03/2011

**P-IRO
Inc.**

An Independent Review
Organization
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**NOTICE OF INDEPENDENT REVIEW
DECISION**

DATE OF REVIEW:
Jan/03/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Spinal Cord Stimulator Placement Lumbar Spine

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH
CARE PROVIDER WHO REVIEWED THE DECISION:**
Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury xx/xx/xx, when he slipped and twisted his left leg.

He is status post L4-S1 fusion. He has had injections and medications. His neurological examination 10/29/2010 shows diffuse weakness of the left leg. A CT myelogram 05/04/2009 showed post-surgical changes at L4-S1 with a fracture of the right L4 pedicle screw and clumping of distal nerve roots, suggestive of arachnoiditis. A psychological

evaluation

05/27/2010 found him to be an appropriate candidate for a spinal cord stimulator trial. He underwent a spinal cord stimulator trial on 09/29/2010. He complains of low back with left leg pain that improved 50% after the stimulator trial. There was an infection associated with the trial.

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

The spinal cord stimulator implantation is not medically necessary. The claimant was reported to have had a 50% decrease in pain from the spinal cord stimulator trial.

However,

according to the ODG, "Pain" chapter, in addition to pain reduction, there should also be "medication reduction or functional improvement after temporary trial." Pain reduction is not the only criterion. This has not been demonstrated or documented in the materials sent for review. Therefore, based on the submitted documentation, the spinal cord stimulator is not medically necessary.

References/Guidelines

2011 *Official Disability Guidelines*, 16th edition
"Pain" chapter:

Indications for stimulator implantation

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)