

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Spinal cord stimulator trial

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

12/2/10, 12/17/10

Ph.D. and Associates, P.C. 11/17/10

Therapeutics, P.A. 1/28/10 to 8/24/10

Imaging 6/22/09

EMG Report 10/19/09

5/10/10

7/9/09

Orthopaedics 7/20/10

Official Disability Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who, according to the medical records, has had two MRI scans, the first one demonstrating bulging discs and the second one showing a small herniation at L4/L5 with possible L5 root compression. He has had epidural steroid injections, which helped, and no selective nerve root sleeve blocks to help identify the pain generator. He is said not to be a surgical candidate by two surgeons. There is no neurological deficit documented on the clinical examinations. Current request is for spinal cord stimulator trial.

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

Upon independent review, the reviewer finds that the previous adverse

determination/adverse determinations should be upheld. This patient does not meet any of the criteria in the ODG Guidelines for a spinal cord stimulator or a trial of such a stimulator. He does not have any neuropathic pain nor chronic post surgical radiculopathy or any of the other possible indications for a spinal cord stimulator trial. The requesting physician has not explained why a spinal cord stimulator trial should be used as a default treatment for a patient who requires repeat epidural steroid injections. It is for these reasons the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Spinal cord stimulator trial.

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)