

Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 04/28/11

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Revision of spinal cord stimulator generator

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since 1993

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Medical necessity has not been demonstrated to approve revision of spinal cord stimulator generator

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
337.22	63688		Prosp.				09/06/08	Z0054 1357	Upheld

**INFORMATION PROVIDED FOR REVIEW:**

- case assignment.
- Letters of denial 03/24/11 & 04/08/11, including criteria used in the denial.
- Treating doctor's evaluations and follow up 02/13/98 – 02/09/11.
- Operative reports – fluoroscopically-guided right lumbar sympathetic block 03/16, 04/16, 04/20, 06/08, 06/11/2009 and 09/13/2010.
- Psychological evaluation 06/22/10.
- Radiology reports 01/31/11 view x-ray T-spine; 09/11/08 3 views right ankle.
- Sports Medicine evaluation 12/26/08, and status report 12/31/08.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This sustained a right ankle fracture on xx/xx/xx. Reflex sympathetic dystrophy developed in the right ankle. A spinal cord stimulator was placed in September 2010. The lead was providing 50% pain relief, but the stimulation pattern changed. It is currently stimulating the thigh, but the stimulation does not extend to the ankle. X-ray reveals migration of the lead from the original position at T11 to T10. Revision

of the lead is requested and has been approved. There is also a request for revision of the spinal cord stimulator generator.

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

ODG Guidelines for spinal cord stimulation have been met. There are no specific guidelines for revision other than the original spinal cord stimulator guidelines. Revision of the spinal cord stimulator generator is occasionally required, but the notes do not indicate why revision of the generator is needed. There is not adequate documentation to warrant revision of the generator.

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

- ACOEM-American 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 judgment, 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 national accepted medical literature (provide a description).
  - Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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