



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

05/03/2011

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 05/03/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Placement of permanent spinal cord stimulator (CPT 63655 & 63685)

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Assignment to 04/13/2011
2. Notice of assignment to URA 04/13/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 04/13/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 04/13/2011
6. Insurance letter 03/29/2011, Appeal 03/29/2011, Insurance letter 03/28/2011, Request for Authorization 03/25/2011, Insurance 03/18/2011, Pre Authorization 03/17/2011, Request for Authorization 03/15/2011, Patient Note 03/04/2011, Referral 02/25/2011, Medicals 02/25/2011, 02/23/2011, 02/07/2011, 01/06/2011, 12/27/2010, 12/03/2010, 09/28/2010, 07/30/2010.
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Patient has a documented work injury date of xx/xx/xxxx. Patient has a history of low back pain that radiates into the legs. On physical exam, there is tenderness with decreased range of motion in that region. Patient is on Zanaflex, Norco, and Ultram, as well as Neurontin. Patient's MRI



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shows disc bulge at L3-L4 and has had epidural steroid injections in the past with a spinal cord stimulator trial that documents gave the patient 60% pain relief. Review request is for placement of permanent spinal cord stimulator (CPT 63655 & 63685).

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

Referring to the Official Disability Guidelines' chapter on pain and spinal cord stimulators, it states that the patient should have a trial and get at least 50% pain relief. The records document that the patient has had a trial and has had greater than 50% pain relief; therefore, the insurer's decision to deny the requested placement of permanent spinal cord stimulator (CPT 63655 & 63685) is overturned as the review records are in support of the ODG recommendations.

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