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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Spinal cord stimulator

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

MD, Board Certified Anesthesiologist

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 ODG

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xxxx. On this date the patient was working with when she heard a pop. The patient has a history significant for three back surgeries: 2002 laminectomy and discectomy, anterior fusion in 2004 and hardware removal in 8/2007. CT of the lumbar spine dated 05/01/07 revealed no evidence of focal canal or neural foraminal compromise at L5-S1 where there has been discectomy, bony fusion, laminectomy and posterior orthopedic hardware placement. MRI of the lumbar spine dated 05/18/07 revealed left laminectomy defect at L5-S1; the patient is status post posterior fusion with metallic instrumentation; bilateral L5 transpedicular and bilateral S1 screws are present; the patient is status post anterior interbody fusion at this level as well. Interbody fusion graft is anchored anteriorly with a single metallic screw. Note dated 10/21/09 indicates that treatment to date includes epidural steroid injection, acupuncture and medication management. There is a gap in treatment records until consultation dated 11/15/10. This note indicates that the patient continues to have excruciating low back pain and lumbosacral radicular symptoms. The patient recently gave birth. This note indicates that treatment to date includes physical therapy, chiropractic therapy, acupuncture, TENS unit and chronic pain program. The patient

was recommended for spinal cord stimulator. Follow up note dated 12/13/10 indicates that the patient underwent psychological evaluation on this date; however, this report is not submitted for review. BBH12 report indicates that the patient is experiencing localized severe pain; the patient is reporting a level of physical illness symptoms that is comparable to what is experienced by the typical non-patient in the community. Initial request for spinal cord stimulator was non-certified on 01/03/11 noting that there is a lack of psychological evaluation in the claimant's records for spinal cord stimulator clearance. The denial was upheld on appeal dated 03/16/11 noting there is no documentation of psychological screening to show that the patient is a proper candidate.

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

The patient is status post lumbar surgery x 3 and continues to complain of significant low back pain. The patient reportedly underwent pre-procedure psychological evaluation; however, the results of this evaluation are not submitted for review. The submitted record contains BBH12 results, which are insufficient to assess the patient's appropriateness for the procedure and to address any potentially confounding issues as required by the Official Disability Guidelines prior to spinal cord stimulator trial/implant. Given the current clinical data, the requested spinal cord stimulator is not indicated as medically necessary at this time. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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)