

US Resolutions Inc.

An Independent Review Organization
1115 Weeping Willow
Rockport, TX 78382
Phone: (361) 226-1976
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
SCS Trial MDT

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgery

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

Official Disability Guidelines
Adverse determination letter 08/02/11
Adverse determination letter 09/07/11
Medical records Back Institute 09/02/10 through 07/18/11 (various providers)
Procedure note diagnostic and therapeutic injection 11/17/10
CT lumbar spine 08/11/09
Radiology report x-rays post-operative lumbar spine 07/19/09
Operative report extreme lateral interbody fusion with reduction of spondylolisthesis at L4-5 and anterior lateral plating at L4-5 07/14/09
Behavior and medicine evaluation/pre-surgical screening 01/16/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female whose date of injury is xx/xx/xx. She underwent a two level lumbar fusion from L2-3 to L3-4. She reportedly had a difficult and prolonged recovery. On 07/14/09 the claimant underwent additional surgery with extreme lateral interbody fusion at L4-5 including anterior lateral plating at this level. CT scan of the lumbar spine on 08/11/09 was performed for right lower extremity weakness. Scan revealed previous lumbar fusion from L2 to L3, additional vertebral screws are placed at L4 and L5. There is grade 1 anterolisthesis of L4 in relation to L5 resulting in borderline central spinal stenosis and moderate bilateral foraminal stenosis. No complicating process was seen regarding hardware placement. Records indicate that the claimant developed significant neuropathy of the right lower extremity subsequent to this most recent surgery. Medications were noted to consist of Norco, Cymbalta and Lyrica. Claimant was noted to continue with chronic intractable back and leg pain.

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

This claimant is noted to have sustained an injury in 2001 and underwent two level lumbar fusion L2-3 and L3-4. She apparently developed adjacent segment disease at the level

below previous fusion, and underwent XLIF on 07/14/09. She has complaints of chronic intractable back and leg pain; however, there is no current detailed physical examination provided documenting her radiating pain to the lower extremities. As noted on previous reviews, no documentation of a psychological evaluation prior to spinal cord stimulator trial was provided. Official Disability Guidelines recommend psychological evaluations especially for patients who present with constant pain and report high overall levels of distress, patients who have the history of failure of conservative therapy, patients who have a history of failed surgery, and patients who have significant psychological risk factors such as substance abuse, serious mood disorders or serious personality disorders.

Noting that there is no indication that the claimant had a psychological evaluation to determine if she is an appropriate candidate for spinal cord stimulator trial, medical necessity is not established at this time. The reviewer finds there is not a medical necessity at this time for SCS Trial MDT.

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)