



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org



NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

Date: November 27, 2012

DATE OF REVIEW: 11/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar spinal cord stimulator trial

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. Texas Dept of Insurance Assignment 11/7/2012,
2. Notice of assignment to URA 11/6/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 11/7/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 11/7/2012
6. Letter to IRO from insurance company 11/9/2012, appeal 10/30/2012, letter to patient from insurance company 10/30/2012, 10/29/2012, appeal request 10/26/2012, medical information for appeal request 10/26/2012, letter to patient from insurance company 9/27/2012, authorization request 9/26/2012, preauthorization 9/26/2012, 9/25/2012, authorization request form 9/21/2012, medical information to patient 8/24/2012, medical documents 8/1/2012, 7/18/2012, 6/16/2012, 5/14/2012, 3/28/2012, 10/31/2011, imaging service report 10/22/2011, 10/12/2011, medical documents 7/7/2011, 3/30/2011, 3/3/2011, 2/23/2011, imaging service report 2/17/2011, 1/31/2011, medical documents 1/26/2011, imaging service report 1/22/2011.

PATIENT CLINICAL HISTORY:



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The patient is a male with a history of ankle pain. The patient has been having pain and was treated with medications, injections and sympathetic blocks. The patient has allodynia and hyperesthesia which was revealed on physical exam. The patient clearly has reflex sympathetic dystrophy of the lower extremity. He has had a psychosocial evaluation with a recommendation for the spinal cord stimulator trial.

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

According to ODG guidelines, the spinal cord stimulator trial is recommended for selected patients unless invasive procedures have failed or are contraindicated. According to ODG guidelines, “there is some evidence supporting the use of spinal cord stimulation (SCS) for failed back surgery syndrome (FBSS) and other selected chronic pain conditions. Spinal cord stimulation is a treatment that has been used for more than 30 years, in the last 5 years has it met with wide spread acceptance and recognition by the medical community. In the first decade after its introduction, spinal cord stimulator (SCS) was extensively practiced and applied to a wide spectrum of pain diagnoses, probably indiscriminately. In the last decade, there has been growing awareness that spinal cord stimulator (SCS) is a reasonably effective therapy for many patients suffering from neuropathic pain for which there was no alternative therapy.”

The indications for stimulator implantation: Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), which the success rate is 70-90 percent, at 14 to 41 months after surgery. This patient has RSD and has not benefited from treatment. The spinal cord stimulator (SCS) trial should be certified for this patient.

The denial of services is overturned.

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



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- 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)**

REFERENCES:

1. Official Disability Guidelines (ODG), Treatment Index, 6th Edition (web), 2008, pain chapter-Psychological evaluations, IDDS & SCS