

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/04/2012

**IRO CASE #:**

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

in office: low back: Bilateral Octrode Dorsal Column Stimulator Trial

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

M.D., Board Certified Anesthesiology

**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

Utilization review determination dated 12/01/11, 12/12/11, 06/09/10, 07/02/10

Notice of independent review decision dated 08/04/10

Letter of medical necessity dated 03/09/10

Office visit note dated 12/06/11, 11/22/11, 07/06/10, 10/12/10, 06/01/10, 02/23/10, 12/10/08, 04/14/10, 06/24/08, 07/24/06

Procedure report dated 10/08/07, 01/07/08

MRI lumbar spine dated 09/17/07

MRI cervical spine dated 09/06/07, 06/27/06

EMG/NCV dated 09/24/07

Psychological evaluation dated 08/23/10, 03/08/10, 05/18/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. She was lifting heavy boxes and a box fell on her. She complained of pain in the neck with radiation to the bilateral upper extremities. She has had physical therapy, diagnostic testing, epidural steroid injections, anterior cervical discectomy and fusion C4-5 and C5-6 on 03/13/07 and individual psychotherapy. MRI of the cervical spine dated 09/06/07 revealed anterior cervical fusion changes at C4-C6; small central protrusion at C2-3; no canal or foraminal stenosis or significant disc herniation or other acute process. MRI of the lumbar spine dated 09/17/07 revealed small focal annular tear in the posterior aspect of the L5-S1 intervertebral disc; no focal herniation or nerve root compression are apparent. The most recent psychological evaluation submitted for review is dated 08/23/10. BDI was 27 and BAI was 30. Diagnoses are psychiatric factors associated with diseases classified elsewhere; and chronic pain syndrome. Office visit note dated 11/22/11 indicates that in the past year the patient has continued with PT and a pain program with Dr.. Physical examination on 12/06/11 notes that

the patient complains of low back pain. Medications include Soma, Vicodin and Zanaflex. Gait and station are normal. There is tenderness off midline bilaterally in a symmetrical distribution in the lumbar paraspinal muscles. Straight leg raising is positive bilaterally producing back and leg pain. A dorsal column stimulator trial was requested and denied.

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

This patient presents with complaints of low back pain with radiation to the lower extremities. The Official Disability Guidelines support dorsal column stimulator for treatment of failed back syndrome, complex regional pain syndrome, post amputation pain, spinal cord injury dysesthesias, pain associated with multiple sclerosis and peripheral vascular disease. The submitted records fail to establish that the patient presents with any of the conditions for which spinal cord stimulation is recommended. Additionally, there is no indication that the patient has undergone a recent mental health screening to establish the patient's appropriateness for the procedure and to address any potentially confounding issues as required by the Official Disability Guidelines. The reviewer finds medical necessity has not been established for in office: low back: Bilateral Octrode Dorsal Column Stimulator Trial. Upon independent review, the reviewer finds that the previous adverse determinations are 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)