

Notice of Independent Review Decision

DATE OF REVIEW: 11/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar revision dorsal column stimulator lead and generator, electrodes and analysis.

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the outpatient lumbar revision dorsal column stimulator lead and generator, electrodes and analysis is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 11/04/13
- Adverse Determination Letter – 09/04/13, 10/07/13
- Prospective IRO Review Response – 11/05/13
- Preauthorization request – 08/28/13, 09/04/13, 09/30/13

- Letter – 08/27/13
- Pre-Certification Request – 08/28/13
- Four pages of Worker's Compensation notes -10/02/07 to 09/03/13
- Appeal/Reconsideration Acknowledgement Letter – 09/30/13
- Surgery Reservation Sheet – 08/15/13
- Notice of Independent Review Decision – 09/26/12
- Copy of Decision and Order of Medical Contested Case Hearing – 07/25/13
- Report of x-rays of the lumbar spine – 04/19/05
- Report of MRI of the lumbar spine – 05/09/05, 10/11/07, 12/23/08
- Report of Electrodiagnostic Findings – 03/25/11
- Report of Lumbar CT myelogram – 08/15/11
- Operative Report – 08/15/11, 11/18/11
- Discharge Summary – 11/21/11
- Report of manual muscle testing and range of motion examination – 01/20/12
- Operative Report – 06/15/06, 04/20/07, 09/20/07, 11/09/07, 07/09/09, 07/30/09, 10/08/09, 10/16/09, 12/31/09
- Admit Note to xxxxxx – 09/18/07
- History and Physical – 07/09/09, 10/08/09, 12/31/09
- Discharge Summary – 04/21/07, 10/16/09
- Admission Note – 04/20/07, 11/09/07
- Confidential Psychological Evaluation – 08/27/09
- Operative Report – 08/13/08
- Report of medical record review – 10/24/07
- Report of Designated Doctor Examination – 10/13/10
- Office Visit Notes – 07/15/11 to 08/27/13

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a lumbar spine injury in xxxx resulting in lumbar spine surgery at levels L4-L5 and L5-S1. On xx/xx/xx, the patient was involved in a motor vehicle accident suffering re-injury to the lumbar spine. He underwent revision of the lumbar surgery in November, 2007. He suffers chronic low back pain and leg pain. He has undergone a number of surgical procedures including facet joint injections, medial nerve root chemical blocks and insertion of a spinal cord stimulator on 10/08/09. Revision of the spinal cord stimulator has been performed without prolonged benefit. The current request is for a revision of the spinal cord stimulator.

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

This patient suffers chronic low back pain and bilateral leg pain with a very complex past history of two separate lumbar spine injuries in xxxx and xxxx. The patient has undergone multiple spinal surgeries including decompressive laminectomies, discectomies at L4-L5 and L5-S1 and a revision surgery with fusion. Additionally, he has been treated with medication, physical therapy, and activity modification. He has

undergone multiple facet joint injections for facet arthrosis. He has also undergone spinal cord stimulator implantation and revision. He continues to suffer chronic back pain. The patient has failed multiple modalities and surgeries for the treatment of chronic low back pain and failed back syndrome. Therefore, it is determined that the denial was appropriate and should be upheld.

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)