

# True Resolutions Inc.

An Independent Review Organization  
500 E. 4th St., PMB 352  
Austin, TX 78701  
Phone: (214) 717-4260  
Fax: (214) 276-1904  
Email: rm@trueresolutionsinc.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Apr/02/2013

**IRO CASE #:**

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

Outpatient ASC Spinal Cord Stimulator Trial

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

PM&R and Pain Medicine

**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 - Official Disability Guidelines & Treatment Guidelines  
Clinical notes dated 01/16/06 – 03/25/13  
Operative report dated 01/30/06  
MRI lumbar spine dated 03/09/12  
Psychological evaluation dated 03/06/13  
Therapy notes dated 01/23/13 – 02/01/13  
Previous utilization review dated 03/11/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury regarding his low back. Per clinical note dated xx/xx/xx, the patient had undergone a spinal cord stimulator trial with minimal improvement. The patient decided against permanent implantation at that time. The note details the patient having previously undergone a spinal fusion in 01/06. The patient was noted to have severe complaints of abdominal pain. The note details the patient utilizing Duragesic patches as well as Xanax, Ambien, Norco, and Methadone. The operative report dated 01/30/06 details the patient undergoing a hardware removal from L3 through the sacrum. The MRI of the lumbar spine dated 03/09/12 revealed post-surgical changes from L1-S1. No evidence of disc

bulges or herniations were noted at that time. Per clinical note dated 04/07/08, the patient complained of low back pain radiating through the back to the left groin. No hernia was found at that time. The clinical note dated 01/27/12 details the patient complaining of low back pain radiating to the lower extremities. The patient was noted to have previously undergone a total of 7 surgeries at the back, elbow, and knee starting in 1995. Clinical note dated 02/05/13 detailed the patient rating the low back pain as 8/10 and describing it as constant and stabbing. Psychological evaluation dated 03/06/13 detailed the patient completing a psychosocial evaluation. The patient was endorsed from a psychological perspective for a spinal cord stimulator. Therapy note dated 01/23/13 detailed the patient completing seven physical therapy sessions to date.

Previous utilization review dated 03/11/13 resulted in a denial for spinal cord stimulator trial secondary to the patient previously undergoing spinal cord stimulator trial and location of pain lacked involvement in the lower extremities.

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

Clinical documentation provided for review notes the patient continuing with ongoing complaints of low back pain. Official Disability Guidelines recommend spinal cord stimulator trial provided that the patient meets specific criteria, including ongoing complaints of low back pain with lower extremity involvement. Clinical documentation details the patient having previously undergone a spinal cord stimulator trial which resulted in very minimal benefit. Given that the patient has previously undergoing spinal cord stimulator trial with no significant benefit, this request does not meet guideline recommendations. As such, it is the opinion of this reviewer that the request for a spinal cord stimulator trial is not recommended as medically necessary.

**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)**