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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jan/14/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Spinal Cord Stimulator Trial with supplies #63650 X 2, 95971 X 1, 95972 X 1, 95973 X 1, L8680 X 16, Lumbar Spine

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 12/11/12, 12/20/12, 11/06/12
Orthopedic report dated 11/20/12, 10/19/12, 07/17/12, 04/18/12, 03/05/12
Manual muscle strength exam lumbar dated 10/19/12
Postmyelogram CT lumbar spine 12/09/11
BHI 2 report dated 09/15/10
Lumbar myelogram dated 07/27/10
Radiographic report dated 07/26/10
MRI lumbar spine dated 04/01/10
Letter dated 12/28/12
IME dated 02/15/12
Operative report dated 02/28/12, 12/09/11, 06/14/11, 01/12/10
History and physical dated 01/12/10
Discharge summary dated 01/14/10

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was picking up a large nylon belt and injured his low back. The patient underwent partial laminectomy of L4 and L5 with foraminotomy L4-S1 on 01/12/10 and lumbar epidural steroid injection on 06/14/11. Lumbar CT dated 12/09/11 revealed no significant disc herniation or bulge, no spinal canal or neural foraminal narrowing T12-L1 through L2-3. At L3-4 there is mild posterior annular disc bulge without significant spinal canal or neural foraminal narrowing. At L4-5 there is mild disc height loss with mild diffuse annular disc bulge and mild ligamentum flavum hypertrophy; no significant spinal canal stenosis, mild right greater than left neural foraminal narrowing is identified. At L5-S1 there is mild posterior annular disc bulge without any significant spinal canal stenosis and no significant neural foraminal narrowing is identified. IME dated 02/15/12 indicates that diagnosis is herniated lumbar disc, L4-5, postoperative state with probable recurrence of herniated disc, L4-5 on the right, and to rule out significant L5-S1 herniated disc. The patient underwent lumbar laminectomy and foraminotomy L4-5 on the right on 02/28/12. Orthopedic report dated 10/19/12 indicates that the patient has been participating in at-home physical therapy and increasing mobility. On physical examination there is tenderness on his mid to lower lumbar region with decreased range of motion to flexion and extension. Straight leg raising elicits leg pain and back pain on the right. He had some motor strength weakness in knee flexors and knee extensors on the right. He had mild paresthesias along his L5 distribution. Deep tendon reflexes are 2+ and symmetric.

Initial request for spinal cord stimulator trial with supplies was non-certified on 12/11/12 noting that there is a significant amount of information lacking. There is no documentation indicating whether the patient's current pain is primarily lower extremity radicular pain or axial low back pain. There is indication that he has had non-interventional treatment; however, details regarding this, particularly with respect to ESIs, are unavailable. There is documentation that he had postoperative physical therapy. There is also documentation that he has had treatment with NSAIDs and muscle relaxants. There is no indication that he has had any behavioral health evaluations since the one included in the first file from xx/xx/xx. While this would technically be a psychological evaluation, it is more than two years old. Since that evaluation, the patient has had another surgery. It would be appropriate to have an updated psychological evaluation given the change in the patient's surgery status as well as the substantial length of time since the prior psychological evaluation. There is no discussion of presence or absence of evidence of substance abuse issues. There is no discussion of contraindications to a trial. The denial was upheld on appeal dated 12/20/12 noting that a psychological evaluation was submitted for review; however, this is dated from mid 2010. Additionally, the clinical notes did not evidence what other conservative modalities the patient has utilized for his pain complaints to his lumbar spine.

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

Based on the clinical information provided, the request for spinal cord stimulator trial with supplies #63650 x 2, 95971 x 1, 95972 x 1, 95973 x 1, L8680 x 16, lumbar spine is not recommended as medically necessary, and the two previous denials are upheld. The patient's most recent surgical intervention was performed in February 2012; however, there is no comprehensive assessment of postoperative treatment completed to date or the patient's response thereto submitted for review. There is no indication that the patient has undergone a recent psychological evaluation clearing him for the procedure. The Official Disability Guidelines require psychological clearance prior to spinal cord stimulator trial to assess the patient's appropriateness for the procedure and to address any potentially confounding issues. Given the current clinical data, the requested spinal cord stimulator trial with supplies is not indicated 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)