

# True Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Jul/05/2013

### IRO CASE #:

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

Permanent spinal cord stimulator

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

Board Certified Neurosurgeon

### 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 05/03/13, 05/15/13

Letter dated 06/17/13

Authorization request dated 05/02/13

Certificate of medical necessity dated 05/01/13

Office note dated 04/23/13

Soap note dated 04/10/13

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. Soap note dated 04/10/13 indicates that the patient is status post lumbar fusion with hardware removal in December 2011. The patient presents for follow up evaluation of his low back and leg pain and removal of his lumbar spinal cord stimulator trial. He had good coverage of his low back and leg pain during the trial. He reports 60-65% pain reduction during the trial. Office note dated 04/23/13 states that the patient reported 70% improvement and would like to proceed with dorsal column stimulator implant. On physical examination patient can toe and heel walk. He can flex and extend with pain in both directions. EHL, DF, PF, Q and H are +4/5 bilaterally. Sensation is decreased on the right L4-5 and L5-S1. Straight leg raising is positive. Faber signs are positive. Deep tendon reflexes are 2/4.

Initial request for permanent spinal cord stimulator was non-certified on 05/03/13 noting that the trial was done with a claimed 70% benefit but there was no mention of med reduction,

pain score reduction or increased physical activity during the trial to support this claim and support an implant. The denial was upheld on appeal dated 05/15/13 noting that per the clinic note dated 04/10/13, "he did not reduce his medications during this trial". Therefore, the patient does not meet ODG criteria for permanent placement of a spinal cord stimulator.

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

The submitted records indicate that the patient underwent recent spinal cord stimulator trial and subjectively reported 70% pain reduction. The Official Disability Guidelines support permanent implantation with evidence of 50% pain relief and medication reduction or functional improvement after temporary trial. The submitted records indicate that the patient did not reduce his medications during the spinal cord stimulator trial, and there are no objective measures of improvement provided to satisfy ODG criteria. Additionally, there is no behavioral health evaluation submitted for review to document psychological clearance as required by the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for permanent spinal cord stimulator 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)