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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/10/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpt removal spinal neurostimulator electrode and spinal neurostimulator and pulse generator system

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Physical Medicine and Rehabilitation 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for outpt removal spinal neurostimulator electrode and spinal neurostimulator and pulse generator system is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Thoracic x-ray dated 02/20/12
Clinical note dated 06/12/12
Operative note dated 08/23/12
Clinical note dated 09/11/12
Clinical note dated 10/25/12
Clinical note dated 04/18/13
Clinical note dated 06/07/13
Adverse determinations dated 06/21/13 & 07/10/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who is noted to have a long history of low back pain. The x-ray of the thoracic region dated 02/20/12 revealed a status post placement of a neurostimulator device. The clinical note dated 06/12/12 details the patient stating the initial injury occurred on xx/xx/xx. The patient subsequently developed neck, low back, and shoulder pain. The patient was noted to have undergone numerous lumbar spinal surgeries to include a prosthetic disc replacement at L4-5. The patient was also noted to have undergone a significant number of additional procedures related to the disc space. The patient was also noted to have undergone numerous epidural steroid injections and other therapeutic modalities. The spinal cord stimulator implantation was completed in 2007. The patient was also noted to have undergone a subsequent procedure in April of 2011 when a paddle was implanted. However, the paddle was noted to have migrated and subsequently was not working properly. The patient was recommended for a removal of the current system with a subsequent 2 lead implantation with 2 generators. The operative note dated 08/23/12 details the patient undergoing an implantation of a spinal cord stimulator bilaterally, 1 on the left, 1 on the right with fluoroscopic guidance. The clinical note

dated 09/11/12 details the patient presenting for a follow up. The patient reported a poor response to the previous implantation of a spinal cord stimulator. The patient reported no significant postoperative relief of pain. The clinical note dated 10/25/12 details the patient continuing with mid and low back pain. Spasms were also noted in the thoracic spine. The patient demonstrated restricted range of motion.

The clinical note dated 04/18/13 details the patient reporting radiating pain into both lower extremities, right greater than left from the low back. The patient rated his pain as 10+/10. The patient stated the pain is constant and described it as a dull, aching, burning sensation. Walking, sitting, standing, bending, driving, twisting, laying down, sneezing, straining, and coughing all exacerbated the patient's pain. The patient reported the spinal cord stimulator providing no significant relief. The clinical note dated 06/07/13 details the patient continuing with radiating pain into the lower extremities. The note does detail the patient having undergone moderate substance abuse to include alcohol, THC, cocaine, and prescription drugs. Additionally, the patient was noted to be utilizing Valium, Marinol, and Oxycodone for ongoing pain relief.

The previous utilization review dated 06/21/13 resulted in a denial for the neurostimulator and electrode explantation secondary to the lack of information confirming the spinal cord stimulator identified as a pain generator.

The utilization review dated 07/10/13 resulted in a denial for the spinal cord stimulator explantation as no objective documentation was submitted supporting the spinal cord stimulator as a pain generator.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation does detail the patient complaining of ongoing radiating pain from the low back into the lower extremities. A spinal cord stimulator explantation would be indicated provided the patient meets specific criteria to include the spinal cord stimulator noted to be a pain generator in the low back. No information was submitted confirming the spinal cord stimulator noted to be a pain generator. The patient was noted to have had a significant number of operative procedures in the lumbar region. It is unclear if the patient has undergone additional studies confirming the spinal cord stimulator as a no longer functioning unit. Given that no information was submitted confirming the spinal cord stimulator acting as a pain generator, this request is not indicated. As such, it is the opinion of the reviewer that the request for outpt removal spinal neurostimulator electrode and spinal neurostimulator and pulse generator system 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)