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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/18/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: OP spinal cord stimulator trial

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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 this reviewer that the request for an OP spinal cord stimulator trial is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back. No information was submitted regarding the initial injury. The operative note dated 09/24/02 indicates the patient undergoing an L5-S1 hemilaminectomy on the right. The operative note dated 12/30/02 indicates the patient undergoing an L5-S1 revision with an L5-S1 posterior interbody fusion with a cage and graft. The operative note dated 04/21/03 indicates the patient undergoing an L5-S1 revision with a repair of the pseudoarthrosis. The operative note dated 10/21/03 indicates the patient undergoing a fusion exploration with retrieval of a pedicle screw. The therapy evaluation note dated 01/12/04 indicates the patient having completed 8 physical therapy sessions to date. The patient reported ongoing stiffness and soreness. The note indicates the patient having significant range of motion deficits throughout the lumbar region. The clinical note dated 10/07/13 indicates the patient continuing with complaints of low back pain that were rated as 6-7/10. The note indicates the patient utilizing Norco on a daily basis. The patient reported lumbosacral regional pain with radiation of pain into the left lower extremity all the way to the left foot. The patient also has an inability to ambulate, stand, or sit for any prolonged period of time. There is an indication the patient is a current smoker and had been advised to cease smoking at that time. The clinical note dated 03/31/14 indicates the patient continuing with chronic low back pain. The note indicates the patient continuing with the use of Norco and Ambien. The clinical note dated 09/29/14 indicates the patient continuing with an aching sensation from the low back into the feet. The patient stated the pain was continuing to affect his sleep hygiene. The patient had been recommended for a spinal cord stimulator trial at that time.

The utilization reviews dated 10/08/14 & 10/24/14 both resulted in denials for the spinal cord stimulator trial as no information had been submitted regarding the patient's psychological assessment, nor had any recent completion of physical therapy been provided in the documentation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of a long history of ongoing low back pain despite a number of surgical interventions throughout the lumbar region. A spinal cord stimulator trial is indicated for patients who have completed all conservative treatments as well as a psychosocial evaluation. There is an indication the patient had undergone 8 physical therapy sessions as of 2004. However, the residual effects for the therapeutic interventions would be very minimal at this time given the 10 year interval. Additionally, no other information was submitted regarding any recent completion of conservative treatments addressing the ongoing low back pain outside of opioid therapy. Additionally, no psychosocial screening was submitted addressing all confounding issues as well as potential outcomes of the pending procedure. Given these factors, the request is not indicated. As such, it is the opinion of this reviewer that the request for an OP spinal cord stimulator trial is not recommended as medically necessary and the prior denials are upheld.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)