

DATE: 11.06.14

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 11.06.14

IRO CASE #:

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

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CT myelogram of the lumbar spine and spinal cord stimulator lead revision

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)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
	<i>Spinal Cord Stimulator</i>		<i>Preauth</i>				<i>xx/xx/xx</i>		<i>Overturned</i>
	<i>Myelogram</i>		<i>Preauth</i>				<i>xx/xx/xx</i>		<i>Upheld</i>

PATIENT CLINICAL HISTORY (SUMMARY):

This worker was injured on xx/xx/xx. Numerous modalities have been utilized, including back surgery and multiple injection procedures. At the 04/07/14 office visit, there was mention that medications include OxyContin and Naprosyn. A spinal cord stimulator was placed on 10/31/06 and repositioned in July 2008 and March 2009. He underwent a right sacroiliac joint fusion on 06/13/14. At the office visit on 08/02/14, there was mention that the spinal cord stimulator had not been functional for one year and there was pain above the surgical site. X-rays showed the lead at T9 with no interruption in the structure of the lead. At an office visit on 04/08/14, there was mention that there was malfunction of the left lead and the right lead resulted in stomach stimulation. Previously, the spinal cord stimulator lead revision was reviewed, based on no indication of lead failure.

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

With regard to the spinal cord stimulator revision, I recommend approving the procedure as requested. Rationale: There is evidence of lead failure, as noted above at the 04/08/14 office visit. Official Disability Guidelines are met for revision of the lead and replacement of the generator.

The office visit on 08/02/14 does not indicate progression of neurologic deficit. Spine imaging studies, per ODG, are indicated if there is progression of a neurologic deficit. This is not the case, as there is no documentation with regard to progression of neurologic deficit. A CT myelogram does not meet ODG criteria.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM-American 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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)