

Notice of Independent Review Decision

DATE OF REVIEW: 07/25/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

SCS Lead Revision and Battery Replacement

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

The TMF physician reviewer is a board certified anesthesiologist with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the SCS Lead Revision and Battery Replacement is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 07/18/14
- Decision Letter – 05/14/14, 06/13/14
- Letter of medical necessity – 07/16/14
- Office Visit Notes – 02/17/14 to 07/14/14
- Office Visit Notes 11/06/12 to 08/13/13
- Report of Mental Health & Behavior Assessment – 09/18/12

- Report of x-rays of the thoracic spine – 09/16/13

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he felt sudden, sharp pain to his lower back and weakness to his legs. He is status post lumbar fusion in 2005 and has been diagnosed with post-laminectomy syndrome of the lumbar region. The patient has an implantable spinal cord stimulator (SCS). He has reported an improved function and overall reduction in pain with medications. However, the SCS left lead has migrated out of place and his battery is not holding a charge long enough for any appropriate amount of time. There is a request for the patient to undergo SCS Lead Revision and Battery Replacement.

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

This patient has chronic post laminectomy pain syndrome and underwent SCS implantation on 02/15/13. At an office visit on 02/21/13 there is documentation of 70 to 80% pain relief. On 03/26/13 there was a loss of stimulation on the left (primary) side. Reprogramming was done and x-rays revealed lead migration. Attempts have been made to approve the repositioning of the leads for over a year. Now the generator will not hold a charge. After permanent implant of the stimulator, there was a marked reduction of pain. However, shortly after, stimulation was lost due to lead migration. The ODG are met for efficacy of SCS implant so lead revision and generator replacement are medically necessary.

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 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)