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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/31/2013

IRO CASE #: 48552

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: spinal cord simulator implant

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:

- 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 spinal cord stimulator implant is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 10/28/13, 11/01/13
Office visit note dated 10/01/13, 09/09/13
Post spinal cord stimulator evaluation dated 09/09/13
Behavioral medical screening dated 07/11/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a 60 year old male whose date of injury is 06/20/2001. Per spinal cord stimulator trial behavioral medical screening dated 07/11/13, the patient sustained lumbosacral injuries with chronic intractable lumbar pain as well as some depression and anxiety as a consequence of chronic pain. Comorbid medical conditions include diabetes and hypertension and possible COPD which has not been diagnosed as the patient smokes two packs of cigarettes per day. The patient has tried epidural steroid injections which provided only short-term relief. There is no indication that the patient suffers from any type of cognitive, memory or emotional impairment rendering him incapable of making informed medical decisions. His anxiety and depression appear to be well-controlled by medications prescribed by his psychiatrist. The patient is not involved in cognitive behavioral therapy at this time, and it is opined that he would benefit from such involvement. The patient underwent spinal cord stimulator trial on 09/09/13. Follow up note dated 10/01/13 indicates that the patient has no prior history of surgery. Medications are listed as gabapentin, Glyburide, Klonopin, lisinopril, Percocet and Zoloft. The patient reports greater than 70% pain relief from the trial. On physical examination there is tenderness to palpation of the lumbosacral spine. Waddell's test was positive. There are no sensory abnormalities noted. No hip, knee or ankle weakness was observed. Deep tendon reflexes are normal.

Initial request for spinal cord stimulator implant was non-certified on 10/28/13 noting that

there is no documentation of a reduction in medication or functional improvement with the trial. There is no documentation of psychological clearance for the requested procedure, which is indicated by the guidelines. The guidelines state that spinal cord stimulators are for failed back syndrome and there is no documentation of any previous lumbar spinal surgery. The denial was upheld on appeal dated 11/01/13 noting that guidelines state that stimulator implantation is indicated for failed back syndrome, complex regional pain syndrome, post-amputation pain, post herpetic neuralgia, spinal cord injury dysesthesias, pain associated with multiple sclerosis, and peripheral vascular disease.

It is noted that the claimant had not undergone any prior lumbar surgery and there was no diagnosis of complex regional pain syndrome or other conditions indicated for spinal cord stimulator implantation. It is also noted that while it was stated that the trial stimulator reduced the chronic low back pain by 70%, there was no indication that increased functioning or reduction in pain medication occurred during the trial period.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in June 2001; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The Official Disability Guidelines support spinal cord stimulators for patients with failed back syndrome, complex regional pain syndrome, post-amputation pain, post herpetic neuralgia, spinal cord injury dysesthesias, pain associated with multiple sclerosis, or peripheral vascular disease. The submitted records indicate that the patient's chief complaint is low back pain, and there is no indication that the patient presents with any of the conditions for which spinal cord stimulator is indicated. Although the patient subjectively reported greater than 70% pain relief after spinal cord stimulator trial, there is no documentation of decreased medication usage or increased functional ability secondary to the spinal cord stimulator trial. As such, it is the opinion of the reviewer that the request for spinal cord stimulator implant 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)