

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jul/09/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** lumbar spinal cord stimulator placement

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Neurological 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 lumbar spinal cord stimulator placement is recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization reviews dated 04/29/14, 06/06/14  
Office visit note dated 05/01/14, 04/03/14, 03/24/14, 04/15/14, 03/24/14, 03/19/14, 08/20/13, 03/06/14, 03/21/14, 01/09/14, 12/06/13, 11/19/13, 10/22/13, 09/24/13, 08/29/13, , 04/15/13  
Preauthorization request dated 01/30/14  
Psychological evaluation dated 01/09/14  
Procedure report dated 03/19/14  
MRI thoracic spine dated 08/03/12, 07/01/09  
Letter dated 05/09/14  
CT thoracic spine dated 07/13/09

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is not described. The patient is status post decompression and fusion at T6-7. Psychological evaluation dated 01/09/14 indicates that she suffers from chronic back pain. The patient's MMPI-2 results are not the best for a person undergoing this procedure, but does not feel strongly that they would counter indicate a trial. She is determined to be a reasonable candidate for a spinal cord stimulator trial. The patient underwent spinal cord stimulator trial on 03/19/14. Note dated 03/24/14 indicates that she reports greater than 50% improvement with the trial. Medications are listed as Cipro, Amitriptyline, Baclofen, Norco, Bactrim, Furosemide, Meloxicam and Norco. Note dated 04/03/14 indicates that pain level is 3/10. Note dated 05/01/14 indicates that pain level is 2/10. On physical examination there is tenderness to palpation of the lumbar bilateral paraspinous muscles. Motor strength is 5/5 throughout. Prescription dated 05/09/14 indicates that during the trial she decreased her hydrocodone from 10/325 q4hours to 10/325 q6hours.

Initial request for lumbar spinal cord stimulator placement was non-certified on 04/29/14 noting that there is no indication the patient has reduced her medication use as it has remained the same from the previous examination date with an added medication of Cipro 500 mg being utilized for 10 days for what is suggested of an antibiotic use post-surgery. The denial was upheld on appeal dated 06/06/14 noting that no apparent reduction in the dosing frequencies of medications was observed around the time of the SCS trial. Furthermore, it was unclear if the patient had exhausted less invasive procedures for her reflex sympathetic dystrophy including injections prior to this request

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient underwent spinal cord stimulator trial on 03/19/14. The patient subsequently reported greater than 50% pain relief. The submitted records indicate that the patient was able to decrease medication usage during the trial. Additionally, the patient increased her ability to stand/walk from 15-30 minutes to 1.5 hours. She was able to increase her ability to sit from 30 minutes to 1/5 hours. Given the patient's reported pain relief, decreased medication usage and increased functional ability, the requested spinal cord stimulator placement is in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for lumbar spinal cord stimulator placement is 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)