

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Feb/24/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** implant neuroelectrodes

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Anesthesiology and Pain Medicine

**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 this reviewer that the requested implant neuroelectrodes is not recommended as medically necessary

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical notes 06/27/13  
Clinical notes 07/25/13  
Clinical notes 08/22/13  
Clinical notes 09/19/13  
Clinical notes 10/17/13  
Clinical notes 11/14/13  
Psycho diagnostic assessment 08/22/13  
IRO 04/11/13  
Adverse determinations 01/13/14 and 01/21/14

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his low back and right lower extremity. Clinical note dated xxxx indicated the patient previously being diagnosed with left knee and ankle osteoarthritis. The patient underwent left hip replacement. Range of motion in the knee was decreased. The patient utilized MS Contin and Norco for ongoing pain relief. Clinical note dated 07/25/13 mentioned the patient continuing with lower extremity and low back pain. Clinical note dated 08/22/13 mentioned the patient continuing with oxycodone for pain relief. Psychotherapeutic evaluation on 08/22/13 indicated the patient stating the initial injury occurred on xx/xx/xx when he was involved in work related incident. The patient reported severe pain at several sites. The patient was an appropriate candidate for spinal cord stimulator trial. Clinical note dated 09/19/13 indicated the patient complaining of throbbing sensation with aching and burning in the low back. Clinical note dated 11/14/13 mentioned the patient complaining of 6-9/10 pain. Previous utilization review dated 01/13/14 resulted in denial for neurostimulator neuroelectrode implantation as no documentation was submitted regarding specific findings regarding likely benefit of a spinal cord stimulator. Utilization review dated 01/21/14 resulted

in denial as no documentation was submitted indicating previous treatment modalities have been fit or having failed.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** Clinical documentation indicates the patient having complaints of low back and lower extremity pain. Implantation of neuroelectrodes would be indicated provided that the patient meets specific criteria, including findings consistent with failed back syndrome, complex regional pain syndrome, post-amputation pain, post-herpetic neuralgia, spinal cord injury with dyesthesia, pain associated with multiple sclerosis, or peripheral vascular disease. No information was submitted regarding significant clinical findings indicating the likely benefit of implantation of neuroelectrodes. Additionally, it is unclear if the patient completed any additional conservative treatment address low back complaints. Given this, it does not appear that the requested implantation of neuroelectrodes would be medically appropriate for this patient at this time. Therefore, it is the opinion of this reviewer that the requested implant neuroelectrodes 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)