

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Apr/29/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

3 reconsideration for the purchase of SCS (spinal cord stimulator) supplies: 1 box Tennafix Antenna skin adhesives, 1 box protective skin wipes, 1 box protective skin wipes, 1 box Hypafix tape for symptoms related to the left knee/leg

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

Board Certified Anesthesiologist

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. Note dated 07/11/07 indicates that the patient underwent left knee arthroscopy that was not very helpful. He had a second arthroscopy which also was of minimal help. He underwent spinal cord stimulator placement and required two surgeries for proper placement. Note dated 11/15/13 indicates the patient complains of left leg and knee pain. Pain is improved by spinal stimulator. Progress note dated 02/14/14 indicates that pain is rated as 5/10. On physical examination there is mild tenderness of the left medial thigh. Strength is 5/5. Sensation is grossly intact to light touch.

Initial request for purchase of SCS (spinal cord stimulator) supplies: 1 box Tennafix Antenna skin adhesives, 1 box protective skin wipes, 1 box Hypafix tape for symptoms related to the left knee/leg was non-certified on 02/20/14 noting that there is a lack of documentation to support the request. The denial was upheld on appeal dated 03/14/14 noting that it is not clear what specific overall functional outcome has been achieved with the spinal cord stimulator system and whether this device continues to work effectively and if this device will continue to be used for the long term.

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

The patient sustained injuries in xxxx and underwent two subsequent knee arthroscopies as well as placement of a spinal cord stimulator. There is no clear rationale provided to support the requested adhesives, skin wipes and tape. The patient's objective, functional response to the spinal cord stimulator is not documented. The issues raised by the initial denials have not been addressed. As such, it is the opinion of the reviewer that the request for 3 reconsideration for the purchase of SCS (spinal cord stimulator) supplies: 1 box Tennafix Antenna skin adhesives, 1 box protective skin wipes, 1 box Hypafix tape for symptoms related to the left knee/leg 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)