

# P-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Sept/23/2014

**IRO CASE #:**

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

Spinal cord stimulator trial

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

Board Certified PM&R

**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.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female whose date of injury is xx/xx/xx. On this date she injured her low back. Treatment to date includes lumbar epidural steroid injections, L5-S1 laminectomy on 02/16/10 and L5-S1 radial discectomy with anterior/posterior fusion with instrumentation on 06/21/11. Hardware block provided no lasting relief, per note dated 09/10/12. Note dated 10/11/13 indicates that she continues to have back and leg pain with neuropathic component and weakness. Medications are effective but she still has functional limitation overall regarding higher level activities. However, medication does allow her to perform basic activities of daily living and small tasks. Office visit note dated 02/03/14 indicates that the patient had a second opinion with a doctor who agrees with a surgical plan of fusion exploration and hardware removal. She continues to exhibit symptoms of RSD with weakness, heat/cold temperature imbalance compared to the left leg and hypersensitivity to pressure from shoe wear. Behavioral medicine evaluation dated 03/06/14 indicates that she recently discontinued long-term use of Zoloft, but did not become depressed. She is not anxious or depressed, not irritable. Pain and impairment relationship scale is 81. Scores in this range show that the client has a sense of entitlement and a feeling that improvement rests on complete pain relief. The client's score may predict poor outcome for medical or surgical intervention, if the patient has several other poor treatment indicators. The patient should benefit by psychotherapy aimed at adjustment and possibly pain control. The patient was cleared for hardware removal and fusion exploration. Request for surgery was subsequently denied. Note dated 07/10/14 indicates they are awaiting the appeals process for consideration of fusion exploration and hardware removal. The patient has continued RSD symptoms of the right lower extremity. On physical examination paravertebral muscles

are tender bilaterally. Lumbar range of motion is painful and restricted. Straight leg raising is normal bilaterally with no issues. Lower extremity strength is symmetrically preset. Deep tendon reflexes are present and normal. Light touch sensation is abnormal at right L5.

Initial request for spinal cord stimulator trial was non-certified on 08/06/14 noting that the patient does not have primarily lower extremity pain. The patient reported back pain greater than leg pain and less often the two were equal. The diagnosis regarding her pain is not clear. In some notes she is stated to have CRPS but there is documentation of normal hair, nails and skin which do not support a diagnosis of CRPS. There was documentation that her pain was due to her hardware rather than CRPS and a request for hardware removal. The psychological clearance done on 03/06/14 was done. It appears he works as does the surgeon requesting the trial. If both are in the same group that would seem to be a conflict of interest. The denial was upheld on appeal dated 08/27/14 noting that the clinical documentation submitted for review indicates that the patient is having more back pain than lower extremity complaints. There is no documentation submitted suggesting abnormal hair, nails and skin. Per Official Disability Guidelines indications for stimulator implantation are primarily lower extremity radicular pain, there has been limited response to non-interventional care such as neuroleptic agents, analgesics, injections, physical therapy, etc.

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

The patient is status post lumbar surgery x 2. The patient currently complains of low back pain greater than lower extremity pain. The submitted records fail to adequately establish the presence of CRPS/RSD. The Official Disability Guidelines note that this is a controversial diagnosis for spinal cord stimulator. Additionally, it should be noted that the prior behavioral health evaluation was performed over 6 months ago and was performed for presurgical screening for a different surgery, namely hardware removal and exploration of fusion. It was noted that the patient should be watched carefully. Pain and impairment relationship scale is 81. Scores in this range show that the client has a sense of entitlement and a feeling that improvement rests on complete pain relief. The client's score may predict poor outcome for medical or surgical intervention, if the patient has several other poor treatment indicators. There is no updated information provided regarding the patient's mental health status. As such, it is the opinion of the reviewer that the request for spinal cord stimulator trial 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)