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**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE NOTICE SENT TO ALL PARTIES:** Aug/19/2015

**IRO CASE #:**

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

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Orthopedic Surgeon

**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 this reviewer's opinion that medical necessity for the request for neurostimulator trial has been established.

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who was injured on xx/xx/xx where he injured his neck and low back. The patient is status post L4-5 bilateral lumbar laminectomy completed on 11/10/14. The patient attended post-operative physical therapy and reported occasional pain involving the left lower extremity. The patient reported an increased amount of numbness and tingling and weakness depending on activities following surgery. The patient continued to see post-operatively. Options for the patient's chronic complaints included epidural steroid injections as physical therapy and anti-inflammatories had provided no benefit. The patient was not approved for lumbar epidural steroid injections. Due to the failure of conservative treatment and ongoing complaints of ongoing low back pain and lumbar radicular symptoms a spinal cord stimulator trial was recommended. The patient underwent a psychological consult on 06/12/15 which found the patient to be an appropriate candidate for a spinal cord stimulator trial. The 06/25/15 clinical record again noted tenderness to palpation in the lumbar region with straight leg raise testing causing both neck and causing both back and leg pain. There was mild weakness in lower extremities mostly due to pain; however, the patient described paresthesia in the outer portion of the lower extremities radiating to the heels. The patient was again recommended for a spinal cord stimulator at this evaluation. The proposed spinal cord stimulator trial was denied by utilization review on 06/17/15 as the psychological evaluation noted severe anxiety and moderate depression. The evaluation did not document realistic expectations for this procedure. The request was again denied on 07/01/15 as the report indicated the last psychological evaluation was before the patient's prior surgery date.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for ongoing complaints of low back pain radiating to the lower extremities with associated numbness and weakness depending on activities. This has not improved with conservative treatment to date to include post-operative physical therapy as well as the use of anti-inflammatories. The patient was unable to obtain approval for epidural steroid injections.

The patient's physical examination noted positive straight leg raise signs with sensory loss and pain in a L5 distribution. The patient had a psychological assessment completed on 06/12/15 which found no concerns regarding the patient's suitability for a spinal cord stimulator trial. The patient was described as dealing well with depressive symptoms and was felt to be optimistic regarding surgery. Given the failure of conservative treatment that has been allowed for the patient to date for ongoing radicular complaints following decompression procedures from November 2010, and the patient did obtain clearance psychologically for the proposed neurostimulator trial, it is this reviewer's opinion that medical necessity for the request for neurostimulator trial has been established and the prior denials are overturned.

**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)