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An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 02/23/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Anesthesiology

Description of the service or services in dispute:

Outpatient implantation of spinal cord stimulators (SCS) for the lumbar spine

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)

Patient Clinical History (Summary)

The patient is a female who was injured on xx/xx/xx. No actual clinical reports, prior imaging, or operative reports were available for review. The patient's history was gleaned from prior utilization reports which noted ongoing complaints of low back pain radiating to the lower extremities. It does appear the patient had a prior spinal cord stimulator trial with lack of post-trial documentation regarding pain response. The patient was noted to have had a pre-trial pain score of 10/10.

The requested spinal cord stimulator implant was denied on 01/05/15 due to the lack of documentation regarding post-trial pain relief or functional improvement as well as medication reduction that would meet guideline recommendations.

The request was again denied on 01/28/15 for the same concerns. There was also a concern regarding the lack of a diagnosis of failed back surgery syndrome or post-laminectomy syndrome.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient has been followed for chronic complaints of low back pain radiating to the lower extremities. In review of the clinical documentation submitted which included prior utilization reports only, there is no indication of a post-trial assessment showing at least 50% improvement of overall pain. There was also no evidence to confirm a diagnosis of failed back surgery syndrome or post-laminectomy syndrome which is the only supported indication for a spinal cord stimulator. Given the overall paucity of clinical documentation to support the request, it is this reviewer's opinion that medical necessity is not established at this time. Therefore, the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical Literature (Provide a description)

- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)