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DATE NOTICE SENT TO ALL PARTIES: June/2/2016

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: DO Board Certified Orthopedic Surgery

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 spinal cord stimulator trial has been established.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX and had been followed for complaints of low back pain radiating to the lower extremities as well as neck complaints. The patient is noted to have had a prior surgical history for the lumbar spine to include lumbar decompression from L4 through S1 based on MRI studies. Prior treatment has included physical therapy, e-stim, and injections. Medications also included the use of gabapentin, meloxicam, and narcotics. The patient had been followed for post-laminectomy syndrome and was being considered for a spinal cord stimulator trial. The patient underwent a psychological assessment on XX/XX/XX which found risk factors to include severe reactive depression and anxiety with a tendency to view himself as disabled by pain with limited functional ability. However, the patient was felt to be a good surgical candidate from a psychological perspective but was recommended for individual counseling following the trial. The XX/XX/XX clinical record continued to note low back pain radiating to the lower extremities rating 8/10 in intensity. The patient's physical examination noted tenderness in the lumbar region over the paravertebral musculature with associated spasms. No focal neurological deficits were identified. The spinal cord stimulator trial was denied by utilization review as there was no documentation regarding psychological clearance.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for post-laminectomy syndrome stemming from a previous lumbar decompression procedure from L4 through S1. The patient has failed conservative management to include injections, physical therapy, the use of durable medical equipment, and several medications including neuropathic medications. The most recent evaluation from XX/XXXX noted ongoing complaints of low back pain radiating to the lower extremities that was severe 8/10 in intensity. The patient's prior imaging studies noted post-operative changes from L4 through S1. The patient had a recent psychological assessment in XX/XXXX which found the patient to be an appropriate candidate for the spinal cord stimulator trial. Based on failure of conservative management and patient's diagnosis as well as the provided psychological clearance, the records provided for review do address the prior reviewer's concerns.

Therefore, it is this reviewer's opinion that medical necessity for the spinal cord stimulator 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)