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DATE NOTICE SENT TO ALL PARTIES: Feb/01/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1 trial of spinal cord stimulator between XX/XX/XX and XX/XX/XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Physical Medicine and Rehabilitation DO, Board Certified Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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 <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for one trial of spinal cord stimulator between XX/XX/XX and XX/XX/XX is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is a female. On XX/XX/XX, a follow up psychiatric note indicated the patient had fallen at work suffering lumbar disc and she had had two back surgeries for chronic radiculopathy and neuropathic pain. She was taking Norco, Lyrica and Cymbalta. She had been seen for neuropsychological consultation but that report was not available. On XX/XX/XX, a psychological pain evaluation occurred, noting the patient had continued treatment for psychotherapy. It is noted because of the fake good response style, potential psychological issues were not detectible as the MMI 2 profile showed an attempt to minimize psychological problems. On XX/XX/XX, the patient was seen in clinic. She described chronic neuropathic pain in the left L5 distribution. She was being treated medically for her depression with clonazepam and Cymbalta. The spinal cord stimulator was again recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a utilization review determination letter was submitted and it was noted that most recent psychological evaluation found no barriers to pain management, but the examiner noted the patient's MMPI-2 profile showed an attempt to minimize psychological problems, and the examiner stated that because of the patient's response style, potential findings for psychological issues would not be detectable. Therefore, the request was non-certified.

On XX/XX/XX, a utilization review determination letter was submitted and it was noted that while the patient normalized complaints of drowsiness, there is no evidence to suggest that modifications in medication regimen had been attempted in an effort to reduce that side effect and documentation revealing psychological clearance was not available for review. Therefore, the request was non-certified.

The guidelines do indicate that a psychological clearance should be obtained prior to

undergoing a spinal cord stimulator trial. The records indicate the patient has been receiving psychological treatment but a clearance for the requested procedure has not been submitted.

It is the opinion of this reviewer that the request for one trial of spinal cord stimulator between XX/XX/XX and XX/XX/XX is not medically necessary and 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 & 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)