IMedReviews
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DATE OF REVIEW: 3/26/2018

IRO CASE # XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
"Spinal Cord Stimulator (SCS) implant 1x16 (x2)" for the patient.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D. Board Certified in Orthopedic Surgery and Sports Medicine.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX with work related injury to XX. This has led to surgical treatment with lumbar fusion from L3-L5. As of the last progress note dated XXXX XX continues to have low back pain with radiation down the back of both legs to the feet. XX pain level was 9/10 and constant at that time. XX is currently being treated with chronic opioid management for failed back syndrome. XX had an SCS trial done XXXX that apparently gave XX relief of 75-100% of XX symptoms which was considered a successful trial and XX wanted to have the permanent stimulator placed. The goal of this is to decrease XX opioid needs. On exam at this last visit XX was noted to have tenderness to palpation of the lumbar spine but not the SI joints. XX had painful ROM. There was a positive R sided straight leg raise but negative on the L. XX was noted to be neurologically intact in both legs. XX has had a psychological evaluation that noted XX was a good candidate for a SCS implant.

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

Per ODG guidelines, the requested "Spinal Cord Stimulator (SCS) implant 1x16 (x2)" is medically necessary. The patient carries a diagnosis of failed back syndrome that has been unresponsive to less invasive pain control measures and XX had a good response to the stimulator trial. XX also has had a positive psychological evaluation in regard to doing the implant.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE KNOWLEDGE BASE
- ☐ 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 GUIGLINES