INDEPENDENT REVIEWERS OF TEXAS, INC.

2150 S. Central Expressway Suite 200-264 McKinney, Texas 75070
Office 214-533-2864 Fax 469-219-3349
e-mail: independentreviewers@hotmail.com

[Date notice sent to all parties]:
04/16/2018

IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
stimulator dorsal column battery replacement, neurostimulator, generator implant, neurostimulator generator implant with rechargeable battery and charging system

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
DO, Board Certified Neurosurgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XX who was injured on XXXX while XX. The claimant developed complaints of low back pain that radiating to the lower extremities. Prior treatment had included physical therapy, chiropractic therapy, medications, and injections without relief. The claimant did have a previous spinal cord stimulator implantation performed in XXXX. The claimant did have a good initial response; however, over time XX indicated that the spinal cord stimulator was not working. The claimant's mediation history was pertinent for XX and XX. No recent imaging of the spine was provided for review. As of XXXX, the claimant reported persistent low back pain that had worsened over time. The claimant also described radiating pain into the lower extremities. The physical exam noted no focal weakness or other neurological deficits. Radiographs were stated to show leads at T10. The ptw as recommended for a lead revision and battery change.

The requests to include stimulator dorsal column battery replacement, neurostimulator, generator implant, neurostimulator generator implant with rechargeable battery and charging system was denied by utilization review as the claimant's pain condition was not well understood. There was limited objective evidence of radiculopathy. There was no clear indication that the claimant had substantially improved with the spinal cord stimulator in place.

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

The records indicate that the claimant has had a history of low back and radicular pain; however, the records did not identify any previous surgical history that would support a current diagnosis of failed back surgery syndrome or post-laminectomy syndrome which are the only indications for a spinal cord stimulator system. The claimant's most recent physical exam findings did not demonstrate any clear evidence of ongoing radiculopathy and there is no indication that the prior spinal cord stimulator provided any significant relief from symptoms. There are no updated psychological assessments, and at this point, the claimant does not meet the current evidence based guideline recommendations for the use of a spinal cord stimulator system. Therefore, it is this reviewer's opinion that medical necessity for the request is not established and the prior denials are upheld.

IRO REVIEWER REPORT TEMPLATE -WC

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 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)**