

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 17, 2004

RE: MDR Tracking #: M2-04-1585-01-SS
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Anesthesiology/Pain Management reviewer (who is board certified in Anesthesiology/Pain Management) who has an ADL certification. The physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Office notes from ___ from February through July 2004
- Office notes from ___ from 2004
- Psychological evaluation from ___ from 5/6/04
- Records from ___ from May 2004
- Office notes from ___ from February 2004
- Office notes from ___ from June 2003 to December 2003
- Office notes from ___ and ___ from November 1999 through 2001
- Operative note from ___ from 6/7/00
- Office visit with ___ from November 2000 through January 2001
- Review by ___ from November 2000
- RME by ___ from February 2001
- Letter from ___ of 7/8/04

Submitted by Respondent:

- Office notes from ___ from 3/25/04
- Office notes from ___ from 2/19/04
- Peer review from ___ from 5/14/04 and ___ from 6/14/04
- Letter from ___ from 5/26/04

Clinical History

The claimant injured his right foot after a very large object fell on it causing a crush injury that resulted in traumatic amputation followed by surgical amputation with debridement of the right foot. The claimant has developed a chronic regional pain syndrome in the right lower extremity. He has been treated with multiple medications and physical therapy which have not significantly reduced his pain. The notes from the current treating physicians state the claimant has had spinal cord stimulation twice in the past, both having to be removed secondary to infection. There is no documentation of a trial for these implantations and more appropriately no documentation of their level of effectiveness while in place prior to being explanted.

Requested Service(s)

Implantation of spinal cord stimulator system to help alleviate pain in the right foot.

Decision

I agree with the insurance carrier and find that the services in dispute are not medically necessary.

Rationale/Basis for Decision

In order for the claimant to be a candidate for spinal cord stimulation, he needs several things, first to have failed conservative treatment modalities. This requirement has been met. Secondly he needs psychological clearance as an appropriate candidate for spinal cord stimulation. There are notes from at least 5 different psychological professionals. There are varying results on his candidacy. The most recent states the claimant was a candidate although just several months prior to that the claimant was found to suffer from a severe major depression/general anxiety disorder, post traumatic stress disorder. It was felt that he had a highly dysfunctional personality and psychological profile. It is at best questionable whether the claimant is an appropriate candidate from a psychological standpoint. The last requirement would be for a trial of spinal cord stimulation that proved to be effective. There is nothing in the current documentation that supports any effectiveness of a trial or documented effectiveness from previous spinal cord stimulators prior to explantation. It is my opinion that this documentation does exist and should be reviewed before recommendation for reimplantation be undertaken, especially in a patient who has had such complications as this claimant has had with previous stimulation.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744

Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 17th day of August 2004.