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IRO Cert#XX

DATE OF REVIEW: DECEMBER 19, 2017

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of the proposed OP Lumbar Spinal cord stimulator with dual leads (63650, 63685, 63663, 95970, 95971, and 95972)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Neurology and Pain Management and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

☐ Upheld (Agree)

XX Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient history: The claimant is XXXX who sustained a work related injury to XXXX low back on XXXX. XXXX underwent fusion surgery at L4-5 and L5-S1 in XXXX, with good recovery and significant reduction of XXXX symptoms. XXXX then sustained another injury in XXXX while performing XXXX duties as XXXX, which exacerbated the lumbar spine condition. XXXX symptoms include pain in the low back with radiation down either or both lower extremities. This worsens with standing, walking, and bending activities. XXXX has been restricted to light duty since then. Treatments have included analgesic medications including NSAID's, muscle relaxers, and opioids. XXXX has undergone physical therapy, epidural steroid injections, as well as lumbar facet blocks followed by radiofrequency ablations. XXXX pain symptoms remained present and continued to restrict XXXX activities. On XXXX, XXXX, XXXX, documented that additional surgery was not indicated, and that XXXX was a good candidate for a trial of spinal cord stimulation (SCS). XXXX was then seen by XXXX, the requesting physician, was granted approval for the trial on XXXX, and underwent the procedure on XXXX. On the XXXX follow-up, the claimant reported having experienced significant pain relief during the trial period – quantified at over 80%. The request for placement of a permanent SCS was denied on XXXX due to lack of objective evidence to corroborate the subjective improvement

during the trial. On XXXX, XXXX provided additional details of the trial – including that XXXX patient was "able to increase activity without taking oral pain medication". Also noted was that "XXXX was able to sleep 5-6 hours at night during the SCS trial" – another apparent change from XXXX baseline. A second denial was determined on XXXX, essentially for the same reasons as the first. On XXXX, XXXX further clarified that the claimant's pain scores had been reduced during the trial to a level of 1/10, whereas XXXX baseline pain levels had ranged from 6 to 9. XXXX was also able to reduce XXXX daily use of medications such as tramadol and cyclobenzaprine.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE: Per ODG, the permanent placement of a spinal cord stimulator requires evidence of 50% pain relief and medication reduction or functional improvement during the temporary trial. The additional details provided by XXXX appear to satisfy these parameters. Therefore, the requested service is medically reasonable in this case.

References: ODG, Clinical Judgment and Medical Experience

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
- ☐ AHRQ- 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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- XX 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)