14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: **6/10/2014**

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Explant spinal Stimulator/ Replace with MRI compatible SCS lumbar Spine.

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

D.O. Board Certified in Anesthesiology and Pain Management.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male who was injured on xx/xx/xx. Subsequently, patient had back surgery and a Spinal Cord Stimulator (SCS) implanted. Patient had SCS explanted in 2005 and another SCS implanted on 09/09/2009. On the last visit to his pain physician dated 03/03/2014, patient complained of neck pain, headaches, arm pain, spasms, weakness, and numbness in the arms. Patient is presently on the following medications: Colace, Lidoderm patches, Oxycodone 15 mg bid, aspirin, Crestor, and Lisinopril. According to the physical exam, patient is getting good relief in his lower back from the SCS.

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

Per ODG references, the requested "Explant Spinal Stimulator/ Replace with MRI-compatible SCS Lumbar Spine" is not medically necessary. The request to explant SCS/ replace with MRI compatible SCS in the lumbar spine is not certifiable. The patient has good relief from present SCS according to the last report dated 03/03/2014. It is not wise to remove a functioning SCS and replace it with an MRI-compatible SCS and subject the patient to possible surgical and anesthetic complications.

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

- ☐ 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