

MEDICAL REVIEW OF TEXAS

DATE OF REVIEW: APRIL 30, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal cord stimulator trial

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

MD, Board Certified in Neurosurgery

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. legal papers dated 3/20/07.
2. Management office notes, extensive and comprehensive, from 11/22/05 to 3/16/07.
3. Operative reports on 12/15/05, 1/12/06, 2/2/06, 2/16/06, 7/13/06, 8/16/06 and 4/5/07, describing SI joint injections, facet joint injections and SI joint rhizotomies.
4. Emergency department records from describing the original injury and temporary hospitalization.
5. Neurologic consultation notes from 7/14/03 dictated by Dr.
6. Orthopedic surgery evaluations describing a fractured right malleolus dated 8/3/03 by Dr.
7. Follow up neurology notes dictated by Dr. from 10/13/04 forward.
8. Dr. office notes and follow ups from 1/10/05 forward.
9. Rehab notes from and Hospital from 7/8/2000 forward.
10. Imaging studies of the patient's knee dated 8/4/03.

11. Independent medical exam performed by Dr. 6/30/04.

PATIENT CLINICAL HISTORY [SUMMARY]:

There were extensive records reviewed on who was injured at work. This gentleman apparently fell on his jobsite, falling down some stairs striking his knee, ankle and hitting his head. Initially, his major complaints were related to his head and he had extensive evaluations of his intracranial content and aside from post concussive syndrome, nothing substantial was found. It should be noted that on 3/1/2000 the patient gave a history of having had suffered a stroke, but this was long before his injury. He also had knee pain which was treated with physical therapy and evaluated by orthopedic surgeons, but he was also complaining of low back pain. On 11/5/03 the patient had a right knee arthroscopy for tear of his lateral meniscus and apparently there were no complications related to this, and throughout the body of the information, this does not become an issue. What is at issue is low back pain. Initially he was described as having lumbar facet syndrome. He has had a number of lumbar facet injections as well as bilateral lumbar medial branch rhizotomy without any substantial improvement. Also note, he was referred to and their information makes up the bulk of the data and is central to the issue. He was initially seen on 11/22/05 and has been evaluated since then all the way to 3/16/07. He has had 7 different surgical procedures involving his SI joint. This began on 12/15/05 at which point he had bilateral SI joint injections with a 50% reduction of his symptoms. Following this he had a lumbar facet block at L4 and L5 with no response. Finally he had bilateral SI joint rhizotomies. This cleared up the left side substantially but left him with approximately 50% of the original right hip and leg pain, and despite two more SI joint injections and one more rhizotomy, the patient continues to complain of right hip and back pain. He has been given the diagnosis of right sacral ileitis. He was also given the diagnosis of degenerative joint disease and radiculitis. Because of this last lack of consistent progress with the SI joint injections, especially on the right side, a spinal cord stimulator has been recommended. He last had a SI joint injection and an S1 and L5 facet joint injections on 4/5/07. There is no response of this. Of note, the patient has been denied the spinal cord stimulator as well as a TENS unit.

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

There is no information provided with regards to the results of the patient's latest injection which was done 19 days ago today. However, the indications for spinal cord stimulators are fairly clear and they

have been dictated by previous reviewers. The general indication for stimulator implant is if all other less than invasive procedures have failed or are contra indicated. This patient seems to be responding to SI joint injections and possibly to the facet joint injections. More importantly and more significantly, he responds very nicely to a TENS unit. I echo the requesting physician's frustration that if a TENS unit is making this patient 100% better, then a TENS unit is exactly what this patient should be given. I think that a spinal cord stimulator, which of course is an invasive procedure (and in this situation does not fall under the standard guidelines for spinal cord stimulation) would be less successful than the TENS unit which has already been found to be 100% successful. It may be necessary to intermittently repeat the right sided SI joint injections, possibly as well as the SI joint rhizotomies, but at this point the patient does not fulfill any of the criteria for spinal cord stimulation secondary to the fact that there are other less invasive mechanisms open to this patient and due to the fact that sacral ileitis is not one of the recognized diagnoses that respond to spinal cord stimulation.

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

- X ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- X 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)**