



REVIEWER'S REPORT

DATE OF REVIEW: 02/27/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Spinal cord stimulator.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., D.O., M.S., Board Certified in Chiropractic, Physical Medicine Rehabilitation, and Pain Management

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. Reports from psychologist dated 12/08/06
2. MRI scan report of lumbar spine on 01/17/06 showing protruding disc at L2/L3 and a solid fusion from L3 to L5
3. Dr report dated 02/09/07
4. Dr.'s reports dated 09/11/06 and 02/22/06 indicating minimal relief following selective nerve block
5. Report from Dr. dated 01/18/07
6. X-ray report of the lumbar spine dated 11/07/06 showing a solid fusion from L3 to S1
7. Report from Dr. dated 11/07/06
8. Myelogram report dated 09/20/06 showing small L2/L3 disc protrusion and solid fusion mass

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The injured employee is a female with a history of falling at work on with her last date of work being. She has a protracted history of problems with regards to her lumbar spine when she underwent a fusion at one level in the lumbar spine. She had another fusion in 1990. She had an anterior cervical discectomy fusion in 1990. She had another low back surgery in 1997. She apparently was found to have a herniated disc in 1995 for which she underwent surgery in 1996. Her recent imaging studies including an MRI scan and myelogram showed a small L2/L3 protrusion with a solid fusion mass caudad from that disc through the sacrum. She was found not to be at maximum medical improvement on 09/11/06. She did not, however, find relief with the selective nerve root blocks sufficient to warrant continued injections. She had a psychological consultation indicating 6 sessions of psychotherapy would be helpful prior to or in conjunction with the spinal cord stimulator implant.

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

This individual has had multiple surgical procedures on her lumbar spine. She does not demonstrate clear evidence of a new surgical lesion. She does have abnormal clinical findings as well as chronic levels of pain that have been unresponsive to any interventions afforded to her. Although she may not be at maximum medical improvement at this point in time, I believe the only options available for her at this point in time for pain relief would be that of a dorsal pump stimulator or a morphine pump. I do not see her as a candidate for a surgical procedure; however, I do not see that a surgeon has been consulted in this regard. Assuming that she is not a candidate for surgical intervention, she would be at maximum medical improvement for all modalities tried thus far with the exception of the dorsal pump stimulator. I do believe that a spinal cord stimulator trial would be reasonable at this point in time assuming she is not found by a spine surgeon to be a viable candidate for surgery.

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

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
- _____ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)