

**DATE OF REVIEW: 6/14/07**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Trial of a spinal cord stimulator, plant electrodes,SCS reprogram (76003), fluoro and MAC anesthesia.

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

This case was reviewed by a board certified anesthesiology on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

**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)

<i>Primary Dx Code</i>	<i>HCPCS /NDC</i>	<i>Mod</i>	<i>Units</i>	<i>Type Review</i>	<i>DOS</i>	<i>Amt Billed</i>	<i>Date of Injury</i>	<i>Claim #</i>	<i>Uphold / Overturned</i>
				Prospective					Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for Independent Review by an Independent Review Organization forms – 6/18/07
2. Determination Notices – 3/19/07, 4/20/07
3. Correspondence from 6/1/07
4. Records and Correspondence from Ph.D. – 2/24/07
5. Peer Review – 3/7/07
6. Records and Correspondence from Radiology Center – 9/27/06
7. Records and Correspondence from DC – 7/31/06-9/13/06

8. Records and Correspondence from MD – 8/28/06
9. Records and Correspondence from MD – 11/17/06
10. Records and Correspondence from MD – 10/27/06

**PATIENT CLINICAL HISTORY:**

This case concerns an adult male who sustained a work related injury. Records indicate that he sustained a low back strain but the records provide no details regarding the circumstances of the injury. Diagnoses have included Lumbar pain with lower extremity pain, numbness and weakness, radiculopathy, epidural scar fibrosis, and right shoulder pain. Evaluation and treatment for this injury has included surgery, a CT/myelogram, an MRI, therapy, medications, and injections.

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

The patient has a history of adult onset diabetes mellitus, substance abuse and depression. He sustained a work related injury with resultant low back pain and right shoulder pain. A trial of a spinal cord stimulator for pain control was recommended by his pain management specialist. The patient's diagnoses include lumbar pain with lower extremity pain, radiculopathy, failed back syndrome following L4-L5 laminectomy and discectomy, epidural scar fibrosis, and right shoulder pain. The patient has undergone pain therapy and treatment at a tertiary pain management program. He continues with low back pain. Records indicate he has highly subjective pain with minimal objective findings. In addition, electro-diagnostic studies for lumbar radiculopathy were negative. The patient has poorly controlled diabetes. There is no evidence to indicate his depression is under adequate control and surgical treatment for pain therapies is not appropriate in patients with significant or untreated psychological or psychiatric disorders. The patient's comorbidities of diabetes, depression and continued substance use would greatly affect the success rate for pain control with spinal cord stimulation therapy. The success rate of spinal cord stimulation in the failed back syndrome population is 40-65% at 5 years. There is no indication at this time that the patient would achieve this level of success given his medical conditions.

Therefore, the requested trial of a spinal cord stimulator, plant electrodes, SCS reprogram (76003), fluoro and MAC anesthesia are not medically necessary for the patient at this time.

**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**
- 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)**