



Notice of Independent Review Decision

DATE OF REVIEW: 4/23/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for trial spinal cord stimulator, with 2 leads (CPT 63650) and programming (95972) with anesthesia and fluoroscopic guidance.

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

Texas licensed Pain Management Physician.

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.

The previously denied request for trial spinal cord stimulator, with 2 leads (CPT 63650) and programming (95972) with anesthesia and fluoroscopic guidance.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice to CompPartners, Inc. of Case Assignment dated 4/14/08.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 4/14/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/11/08.
- Company Request for Independent Review Organization dated 1/4/08.
- Request for a Request for a Review by an Independent Review Organization dated 1/4/08.
- Medical Records/Documents Submitted Cover Letter dated 4/15/08.
- Determination Notification Letter dated 12/5/07, 11/21/07.
- Electromyogram and Nerve Conduction Studies Report (EMG/NCS) dated 3/17/08.
- CompPartners Peer Reviewer Final Report dated 12/5/07, 11/21/07.
- Reconsideration Request Letter dated 11/29/07.
- Pre-Authorization Request Form dated 11/20/07.
- Health/Behavior Intervention Office Visit Report/Letter dated 11/14/07.
- Follow-Up Evaluation Report dated 11/27/07, 10/31/07, 4/18/07.
- Patient Follow-Up Report dated 8/27/07, 8/6/07.
- Follow-Up Office Visit Report dated 12/18/06, 11/9/06, 10/16/06
- Pain Evaluation and Treatment Report/Letter dated 1/4/07.
- Initial Complex Consultation Report dated 9/27/06.
- Lumbar Spine MRI dated 12/4/05.

No guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Slip and fall.

Diagnosis: Lumbar syndrome, bilateral chronic knee pain, status post multiple surgical treatments to include the knees bilaterally, bilateral hip contusion and chronic pain behavior (depression).

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

This claimant is a morbidly obese male who sustained a work-related injury secondary to a slip and fall mechanism. The current diagnoses include:

1. Lumbar syndrome.
2. Bilateral chronic knee pain.
3. Status post multiple surgical treatments to include the knees bilaterally.

4. Bilateral hip contusion.
5. Chronic pain behavior (depression).

Subsequent to this claimant's injury, he underwent extensive surgical treatment for his knees to include injections and arthroscopic surgery bilaterally. Due to continued low back pain complaints, a lumbar MRI was performed on December 4, 2005, and revealed moderate-to-severe, right greater than left, L5 neuroforaminal narrowing related to posterior lateral disk bulging and a degenerative L5 spondylolisthesis; mild multilevel degenerative disk disease. This claimant had undergone conservative treatment for the lumbar spine to include physical therapy and medication management, which included Hydrocodone 2 to 4 per day, Ultram ER 200 mg, Cymbalta 60 mg 1 p.o. q.d., Flexeril 10 mg p.r.n., and lumbar epidural steroid injections. Accordingly, from the UM nurse summary, it appeared that the claimant's pain improvement was documented of at least 70% to 80% with medication management per Dr.. A designated doctor evaluation performed by Dr. submitted on October 4, 2007, placed this claimant at maximum medical improvement (MMI) with 12% whole-person impairment rating for his knees and 5% whole-person impairment rating for his lumbar spine. Submitted utilization reviews for the lumbar spinal cord stimulator trial were denied secondary to the fact that the claimant had never had any type of previous back operation and the reviewers were unclear whether this claimant's pain was primarily nociceptive or neuropathic; the request does not meet the Official Disability Guidelines criteria for trial of lumbar spinal cord stimulator.

In the last submitted note from the requesting provider, Dr. dated November 27, 2007, his opinion was that the claimant "clearly has neuropathic pain as he continues to have back pain radiating to the hips, buttocks all the way down both legs, right greater left." In addition, the claimant had numbness and tingling in the back and both lower extremities all the way to the feet, with weakness in the lower extremities and a burning sensation in the back. It appeared that the claimant finally underwent electromyographic/nerve conduction studies (EMG/NCS) of the lower extremities performed on March 17, 2008, which were read as normal, except for slightly slow motor conduction in the right tibial nerve; this suggested possibility of early neuropathy; there was no evidence of lumbar radiculopathy. The study was performed by M.D.

This reviewer has reviewed the information submitted. The previous non-authorization for a trial of lumbar spinal cord stimulator has been upheld. The current objective diagnostic studies performed did not reveal any neuropathic or radicular type symptoms correlating with the claimant's subjective complaints. In addition, radiographic imaging studies, i.e., lumbar MRI, reportedly did not reveal any significant disk herniation, nerve root compression, and/or spinal cord stenosis. The requesting provider has not demonstrated the medical necessity for the above interventional pain management procedure. In addition, the request does not meet the Official Disability Guidelines criteria for indications of a trial of lumbar spinal cord stimulator trial, which includes:

1. Failed back surgery syndrome.
2. Complex regional pain syndrome.
3. Post-amputation pain (phantom limb pain).

4. Postherpetic neuralgia.
5. Spinal cord injury, dysesthesias.
6. Pain associated with multiple sclerosis.
7. Peripheral vascular disease.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
Official Disability Guidelines, Treatment Index, 6th Edition, 2008 (web) under spinal cord stimulator indications.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).