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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Peripheral Nerve Stimulator Trial

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Peripheral Nerve Stimulator Trial	64555	-	Upheld

PATIENT CLINICAL HISTORY (SUMMARY):

The requesting physician is Dr. The patient's date of injury was xx/xx/xx. The request is for a peripheral nerve stimulator trial and permanent implantation of peripheral nerve stimulator (if trial is successful). Diagnoses are mononeuritis and lesion of medial popliteal nerve.

The mechanism of injury was bending that caused back pain requiring a fusion, site unknown. Patient continues with moderate to severe LBP radiating to both heels. There is mild relief of pain with medications. He had bilateral SI joint injections on 10/24/07 and right SI joint injections on 10/24/07 and right SI joint injections on 11/28/07. Exam revealed lumbar paraspinal SI joint tenderness. He had a previous permanent SCS implanted that failed to cover the main pain source, the low back. The plan was to do a trial PNS

hoping to decrease low back pain. Psychological evaluation was done on 05/07/08 by Dr. PhD and this revealed risk factors being workers' comp, on-going litigation, pain greater than 12 months, 2 prior spine surgeries, pain sensitivity, chronic depression/anxiety and disability income. His diagnoses were adjustment with mixed anxiety/depression. In spite of the multiple risk factors cited, Dr. stated the psychosocial risk for a poor surgical outcome was low. He recommended surgery and behavioral treatment post-op. There was no documentation of objective signs of radiculopathy, only subjective pain complaints of bilateral leg pain. He was on OxyContin 180 mg/day, Oxy IR 15 mg/day, and Cymbalta 120 mg/day, Xanax 3mg/day, Lyrica 100mg/day, and Celebrex.

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

The patient is a xx-year-old man with chronic low back pain and bilateral leg pain since 1999. A back fusion at L3-4 failed to relieve the pain. A SCS permanent implant failed to cover his low back pain and bilateral leg pain. He continues with significant complaints of pain despite consuming large doses of opiates, anti-depressants, and anti-convulsant medication. He is also on large doses of Xanax daily. The spine diagnoses

are not clearly delineated. Dr. states there is a mononeuritis, unspecified site and a medical lesion of the popliteal nerve. How do these diagnoses relate to the index injury? There has been no documentation of a popliteal nerve injury. Similarly, he states that with the peripheral nerve stimulator he will be able to stimulate the damaged peripheral nerves. However, he has not identified these damaged nerves. He has been injecting the SI joints in an apparent effort to control the pain. Yet, the pain is emanation from the back and radiating to the feet by documentation. The SI joints are well known not to refer pain beyond the proximal thighs posteriorly and beyond the L5-S1 area.

SCS research utilizing high quality randomized control trials are quite few. However, these few trials have concluded that SCS is of benefit for neuropathic pain and not for nociceptive pain. This patient's majority pain appears to be nociceptive. There has been no documentation of objective signs of radiculopathy or nerve root compression. Neuropathic pain is defined as pain arising from a lesion to the peripheral nervous system, as in diabetic or AIDS poly-neuropathy, post-herpetic neuralgia or lumbar radiculopathy, or from a lesion to the central nervous system as in spinal cord injury, multiple sclerosis, or stroke (The Spectrum of Pain, , M.D., Chapter 2, pgs 18-19, Dec 2005).

In sum, in neuropathic pain, there is an underlying cause which is identifiable. This is certainly lacking in this case. Moreover, the psychological evaluation revealed multiple risk factors that would predict a poor surgical outcome. These included ongoing litigation, workers' compensation, severe pain unrelieved by large doses of opiates, depression/anxiety, pain greater than a year, two or more spine surgeries, receiving disability income and older age group which was not included under risk factors by the examiner. The spine literature does not support spinal surgery with these many risk factors and does not agree with Dr. recommendation to proceed with surgery.

Even with clear documentation of mainly neuropathic pain, surgery would not be recommended in the presence of these many risk factors.

In sum, based upon the clinical information, the rationale discussed above and evidence-based peer reviewed guidelines, the requested procedure of peripheral nerve stimulator trial and permanent implantation of peripheral nerve stimulator (should trial prove successful) is not certified.

ODG Treatment on-line, Lumbar, Spinal cord Stimulator states:

Recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated. See the [Pain Chapter](#) for *Indications for stimulator implantation*. There is some evidence supporting the use of Spinal Cord Stimulation (SCS) for Failed Back Surgery Syndrome (FBSS) and other selected chronic pain conditions. Spinal Cord Stimulation is a treatment that has been used for more than 30 years, but only in the past five years has it met with widespread acceptance and recognition by the medical community. In the first decade after its introduction, SCS was extensively practiced and applied to a wide spectrum of pain diagnoses, probably indiscriminately. The results at follow-up were poor and the method soon fell in disrepute. In the last decade there has been growing awareness that SCS is a reasonably effective therapy for many patients suffering from neuropathic pain for which there is no alternative therapy. There are several reasons for this development, the principal one being that the indications have been more clearly identified. The enhanced design of electrodes, leads, and receivers/stimulators has substantially decreased the incidence of re-operations for device failure. Further, the introduction of the percutaneous electrode implantation has enabled trial stimulation, which is now commonly recognized as an indispensable step in assessing whether the treatment is appropriate for individual patients. These implantable devices have a very high initial cost relative to conventional medical management (CMM); however, over the lifetime of the carefully selected patient, SCS may lead to cost-saving and more health gain relative to CMM for FBSS. See the [Pain Chapter](#) for complete list of references. Fair evidence supports the use of spinal cord stimulation in failed back surgery syndrome, those with persistent radiculopathy after surgery. ([Chou, 2008](#))

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

ODG:

ODG Treatment on-line, Lumbar, Spinal cord Stimulator

