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Notice of Independent Review Decision

MAY 7, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

TRIAL SPINAL CORD STIMULATOR

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

Board Certified in Neurological Surgery

REVIEW OUTCOME

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

X Upheld	(Agree)
Overtured	(Disagree)
Partially Overtured	(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

Table of Disputed Services

Notification of Determination – 3/13/08

Utilization Review Letter –Ins. Co. – 4/10/08

C-IRO Decision – 12/17/07

MRI of the lumbar spine – 12/12/2000; 5/29/02; 4/23/04

CT lumbar spine, including reconstructed sequences imaging – 8/13/07

X-ray chest PA & Lateral – 4/21/08

MRI of the right knee – 5/29/02
Clinical evaluation and notes –, D.O. 6/23/05 – 2/28/08
Clinical report – M.D. – 4/26/07
DDE Impairment Rating Report – 1/31/03
ODG Guidelines

PATIENT CLINICAL HISTORY: SUMMARY OF EVENTS:

This case involves a xx-year-old female who was injured at work in xx/xx. She was walking through a company parking lot leaving work to go to her car. She tripped and twisted her spine in trying to prevent a fall. She fell despite this and injured her right hand and right knee. Primary care physicians were seen and medication was prescribed. Chiropractic treatment led to acupuncture and massage therapy without much benefit. A diagnosis of a strain in the lumbar, thoracic and cervical spine and right shoulder and right knee was made. The patient has had physical therapy, medications, epidural steroid injections, lumbosacral sympathetic blocks and stellate ganglion blocks. She has also had surgery on her right knee and right shoulder. An EMG in May of 2002 showed a right L4-5 and S1 radiculopathy and lumbar MRI done in April 2004 showed a potentially surgically significant disc protrusion at L5-S1. Discography was also carried out and was positive at L5-S1. Surgery was recommended at the L5-S1 level including disc replacement. This was turned down several times by the workers compensation insurance carrier. Spinal Cord stimulation has now been recommended in a trial stimulator is the initial procedure to be carried out.

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

I agree with the benefit company's decision to deny implantation of a spinal cord stimulator. One of the diagnoses is fibromyalgia and spinal cord stimulation certainly is not indicated for such a problem. In addition, the patient has significant shoulder and right upper extremity discomfort with a 4/26/07 report indicating shoulder, elbow, wrist and head pain. None of these would be taken care of by a spinal cord stimulator directed at low back and lower extremity discomfort. Potential pain production from cervical disc disease is also present and as evidenced by an MRI, which was obtained, for neck and arm pain. When there are multiple areas of pain, the relief of one is often no benefit.

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)**