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DATE OF REVIEW: 06/26/09

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal Cord Stimulator Trial

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 11-21-08 Consultation report from Dr.
- 11-12-08 Office visit report from Dr.
- 02-17-09 Office visit report from Dr.
- 04-02-09 Pre-cert request for Spinal Cord Stimulator Trial from Dr.
- 04-08-09 Determination Letter from IMO
- 04-13-09 Pre-cert request for Spinal Cord Stimulator Trial from Dr. reconsideration
- 04-20-09 Determination Letter on reconsideration from IMO
- 05-05-09 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews, the patient has a history of industrial back pain which developed into chronic radicular pain despite surgical intervention. He has been using an intrathecal pain pump using Morphine Sulfate 1 mg/cc per day up to 30 cc daily. On October 21, 2008 the patient's provider noted an increase in pain since his medication was titrated down and he has been seen in emergency rooms on some occasions. On October 21, he was provided Cymbalta which he appears to tolerate. His range of motion appears worse than prior due increase in pain but he has no new numbness or weakness.

The medical report of November 12, 2008 notes the patient continues with increased pain and desires to reinitiate use of the intrathecal pain pump. Request is made to refill his pain pump.

On February 17, 2009 the patient's intrathecal pain pump was refilled with Hydromorphone 1 mg/cc with a total of 30 cc. Recommendation is for a trial of spinal cord stimulation.

Request for trial of a spinal cord stimulator was not certified in review on April 8, 2009 with rationale that a prior attempt of spinal cord stimulation failed ("It was not helpful.") and an intrathecal pain pump was implanted as an alternative.

Request for reconsideration of a spinal cord stimulator was also not certified in review on April 20, 2009 following a peer discussion. Past surgical history is significant for a prior SCS trial (no benefit), and a 360 degree lumbar fusion at L4-S1 in August 2001. He was deemed MMI in May 2003 with 20% impairment. The patient tried a SCS in the past without benefit. The provider agrees with the use of medical resources and is reluctant to proceed with the SCS trial. The patient is stable with good pain reduction with an intra-thecal hydromorphone pump. ODG would not support re-trial of a previously non-effective modality.

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

Per ODG, spinal cord stimulation is recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated. 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 is fair evidence that spinal cord stimulation is moderately effective for failed back surgery syndrome with persistent radiculopathy, though device-related complications are common.

The patient is stable with low dose intrathecal pain pump and has previously failed attempt of a spinal cord stimulator. The patient has an intra-thecal pain pump as an alternative therapy. I would agree with the prior reviewer that ODG would not support re-trial of a previously non-effective modality. Therefore, my recommendation is to uphold the previous non-determination for trial of a spinal cord stimulator.

The IRO's decision is consistent with the following guidelines:

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

__X___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

The Official Disability Guidelines, Low Back (5-28-2009) Spinal Cord Stimulator:

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, according to the recently released joint American College of Physicians/ American Pain Society guideline recommendations on surgery and interventional treatments. (Chou, 2008) The National Institute for Health and Clinical Excellence (NICE) of the UK just completed their Final Appraisal Determination (FAD) of the medical evidence on spinal cord stimulation (SCS), concluding that SCS is recommended as a treatment option for adults with failed back surgery syndrome lasting at least 6 months despite appropriate conventional medical management. (NICE, 2008)

Recent research: New 24-month data is available from a study randomizing 100 failed back surgery syndrome patients to receive spinal cord stimulation (SCS) plus conventional medical management (CMM) or CMM alone. At 24 months, the primary outcome was achieved by 37% randomized to SCS versus 2% to conventional medical management (CMM), and by 47% of patients who received SCS as final treatment versus 7% for CMM. All 100 patients in the study had undergone at least one previous anatomically successful spine surgery for a herniated disk but continued to experience moderate to severe pain in one or both legs, and to a lesser degree in the back, at least six months later. Conventional medical therapies included oral medications, nerve blocks, steroid injections, physical and psychological therapy and/or chiropractic care. (Kumar, 2008) There is fair evidence that spinal cord stimulation is moderately effective for failed back surgery syndrome with persistent radiculopathy, though device-related complications are common. (Chou3, 2009