



Specialty Independent Review Organization

## Notice of Independent Review Decision

**DATE OF REVIEW:** 5/25/09

**IRO CASE #:**

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

The services under dispute include SCS trial cervical lumbar 63650 and 95972.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation as well as electrodiagnostic medicine. This reviewer has been practicing for greater than 10 years.

### **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)

The reviewer agrees with the previous adverse determination in all its parts.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

Dr.

These records consist of the following (duplicate records are only listed from one source): Dr. 4/29/09 denial letter, 3/31/09 preauth request, 4/15/09 preauth request, 4/16/09 denial letter, 4/3/09 report by DO, 10/13/08 pelvic and L-spine CT reports, 3/20/08 and 7/17/08 reports by DO, 4/19/07 rad report by Dr. , 4/19/07 rad report by , DC, 2/06/08 cervical MRI report, 2/6/08 lumbar MRI report, 1/5/09 report by MD and 11/25/08 report by MD.

3/18/09 report by PhD.

We did not receive a copy of the WC Network Treatment Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured while at work on xx/xx/xx secondary to a motor vehicle accident. The work up has been significant for an ovarian mass and lumbar facet arthrosis. Lumbar facet blocks were offered. A spinal cord stimulator trial has been recommended for chronic cervical and lumbar spine pain as well as shoulder and groin pain.

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

The criteria for a spinal cord stimulator placement as per the ODG are as follows:

- . Failed back syndrome (persistent pain in patients who have undergone at least one previous back operation and are not candidates for repeat surgery), when all of the following are present: (1) symptoms are primarily lower extremity radicular pain; there has been limited response to non-interventional care (e.g. neuroleptic agents, analgesics, injections, physical therapy, etc.); (2) psychological clearance indicates realistic expectations and clearance for the procedure; (3) there is no current evidence of substance abuse issues; (4) there are no contraindications to a trial; (5) Permanent placement requires evidence of 50% pain relief and medication reduction or functional improvement after temporary trial. Estimates are in the range of 40-60% success rate 5 years after surgery. Neurostimulation is generally considered to be ineffective in treating nociceptive pain. The procedure should be employed with more caution in the cervical region than in the thoracic or lumbar due to potential complications and limited literature evidence.
- . Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), 70-90% success rate, at 14 to 41 months after surgery. (Note: This is a controversial diagnosis.)
- . Post amputation pain (phantom limb pain), 68% success rate-  
Post herpetic neuralgia, 90% success rate . Spinal cord injury dysesthesias (pain in lower extremities associated with spinal cord injury)
- . Pain associated with multiple sclerosis
- . Peripheral vascular disease (insufficient blood flow to the lower extremity, causing pain and placing it at risk for amputation), 80% success at avoiding the need for amputation when the initial implant trial was successful. The data is also very strong for angina.

Secondary to the ODG criteria for SCS placement not being met. This procedure is found to be not medically necessary 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)