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Notice of Independent Review Decision

September 3, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Spinal cord stimulator trial to include CPT code # 77003, 72275, 65971, 63650.

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

Diplomate, American Board of Orthopaedic Surgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier/URA include:

- Medical Imaging, 02/21/03, 11/21/03
- Medical Center, 12/22/03

- Back Institute, 11/29/06, 02/27/07, 05/29/07, 08/28/07, 11/26/07, 02/22/08, 03/26/08, 04/09/08, 05/02/08, 09/17/08, 01/13/09, 05/13/09, 06/01/09, 06/16/09
- Ph. D., 06/15/09
- Management Fund, 06/30/09, 07/02/09, 08/04/09, 08/21/09
- Official Disability Guidelines, 2008

Medical records from the Requestor/Provider include:

- Medical Imaging , 02/21/03, 11/21/03
- Medical Center, 12/22/03
- Back Institute, 11/29/06, 02/27/07, 05/29/07, 08/28/07, 11/26/07, 02/22/08, 03/26/08, 04/09/08, 05/20/08, 09/17/08, 01/13/09, 05/13/09, 06/01/09, 06/16/09, 08/10/09
- Ph. D., 06/15/09

PATIENT CLINICAL HISTORY:

The patient is xx-year-old, white female who injured her back and right hip while working at a cafeteria for Independent School District, while placing a box of meat on a lower shelf.

The patient failed conservative care and underwent decompression from L3 to S1, with L4 to S1 fusion and pedicle screw instrumentation.

The patient also underwent a right total hip arthroplasty and had to undergo three revision surgeries for failure of surgery.

The patient continues to have right hip pain. The latest imaging revealed the aforementioned lumbar surgery with extensive and diffuse lumbar degenerative disc disease from L1 to S2 (She has a transitional vertebra).

The patient went through a chronic pain management program and was able to taper her opiates, however, D.O., in May of 2009 noted that her pain had increased and had to increase opiates.

The patient continued to refuse long-acting opiates. She was referred to, M.D. for spinal cord stimulator trial. Dr. examined her in June of 2009 and noted axial pain mainly, with no objective signs of radiculopathy. He also noted right hip pain from her multiply revised right total hip.

A brief psychological screen was performed. Dr., the examining psychologist, did not feel an MMPI-2 was necessary because it was clear to him that she had no psychological barriers for an invasive procedure.

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

Per ODG, spinal cord stimulators are indicated only after all conservative measures have been exhausted. This includes treatment with long-acting opiates. It is also recommended only after all pain generators have been defined. The spinal cord stimulators are not recommended mainly for axial pain, which this patient mainly has. It is best for neuropathic pain and radiculopathy and ineffective for nociceptive pain. More likely than not, a major portion of this patient's lumbar pain is from her scoliotic/osteoarthritic spine, and her right hip pain is coming from her multiply revised total hip. The spinal cord stimulators would be ineffective in treating this type of pain (ODG, Pain Chapter, 2008). Even in the best of circumstances, with all the proper indications in place, best results are only in the 50% range (ODG, Pain Chapter, 2008). Therefore, based upon the above rationale and peer reviewed guidelines, the request for a spinal cord stimulator trial is not certified.

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)**