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Notice of Independent Review Decision

DATE OF REVIEW: 03/22/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Percutaneous octrode lead neurostimulator trial

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

Texas Board Certified Physical Medicine & Rehabilitation
Fellowship Trained Pain Management

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Pain Specialist, follow-up notes, dated 10/14/08 to 12/14/09
2. Pain Specialist, drug form, dated 12/20/08 to 02/19/10
3. Psychological report, Dr., dated 10/22/09
4. Letters of medical necessity/reconsideration, dated 01/14/10, 02/03/10, and 02/16/10
5. Prior reviews, dated 01/22/10 to 02/11/10
6. Cover sheet and working documents
7. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx.

A clinical note dated 10/14/08 reported the employee was diagnosed with chronic SI joint pain, insomnia, anxiety and depression.

A clinical note, dated 02/26/09 reported the employee complained of increased pain at the wrist levels.

A clinical note, dated 05/14/09, reported the employee complained of increased left lower extremity pain. Physical examination reported an antalgic gait, cervical facet pain, lumbar paraspinal pain, bilateral SI joint pain, positive bilateral straight leg raise, and reduced range of motion.

A clinical note dated 10/22/09 reported the employee was “psychologically clear” for intrathecal medication pump implantation trial.

A clinical note dated 12/14/09 reported the employee complained of pain radiating to the toe. Physical examination reported an antalgic gait. A letter of medical necessity dated 01/14/10 reported the employee was recommended for a dual percutaneous octrode lead neurostimulator trial for treatment of chronic pain. The note reported that prior surgeries to include lumbar laminectomy have failed to control the employee’s pain. The note also reported that medication management had failed to control the employee’s pain to include Naprosyn, Effexor, Hydrocodone, Ambien, Gabapentin, Robaxin, and Xanax. The note also reported the employee was not a surgical candidate.

A prior review dated 01/22/10, reported the request for a spinal cord stimulator was not medically necessary. Prior review reported that request was denied secondary to limited evidence of conservative treatment to include physical therapy. A letter of reconsideration dated 02/03/10 reported the employee had been unresponsive to other measures to include medication management and surgical intervention. The note reported the employee was not a surgical candidate and was recommended for spinal cord stimulator trial.

A prior review dated 02/1/10 reported request for spinal cord stimulator was not medically necessary at this time. The review reported that the request was denied secondary to no evidence-based studies supporting the treatment of neuromuscular electrical stimulation for chronic pain.

A letter of reconsideration dated 02/16/10 reported again that the employee had not responded to other measures to include surgical intervention and medication management.

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

The request for percutaneous octrode lead neurostimulator trial is not medically necessary. Documentation indicated that the employee was previously treated with a lumbar laminectomy and medication management. There was also limited clinical documentation submitted for review to indicate the employee has primarily lower extremity radicular pain. In addition, the psychological evaluation submitted for review indicated the employee is “psychological cleared” for intrathecal medication pump implantation trial. There is no indication that the employee has received psychological clearance for a spinal cord stimulator trial. As such, medically necessary for percutaneous octrode lead neurostimulator trial has not been established at this time.

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

Official Disability Guidelines Pain Chapter

Indications for stimulator implantation:

- 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.