

# Clear Resolutions Inc.

An Independent Review Organization  
7301 RANCH RD 620 N, STE 155-199A

Austin, TX 78726

Phone: (512) 772-4390

Fax: (512) 519-7316

Email: resolutions.manager@cri-iro.com

## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE OF REVIEW:

Aug/01/2010

### IRO CASE #:

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

Lumbar laminectomy with insertion of the paddle electrode and SCS implantation

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

MD, Board Certified Neurosurgeon

### 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

2010 Official Disability Guidelines, 15th edition, "Pain" chapter:

Notices of Adverse Determination, 6/16/10, 7/2/10

M.D. 6/21/10

Orthopedic Group 6/7/10, 4/8/10, 3/22/10, 3/18/10

Imaging 10/29/08

Imaging Center 12/16/08

Interventional Pain Associates 4/22/10, 5/11/10

Radiology Exam Summary 2/10/10, 7/16/09, 6/12/09

### PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury xx/xx/xx, when a pipe fell on his shoulder and he fell 10-15 feet from a lift. He is diagnosed with failed back syndrome. He is status post L3-L4 laminectomy in 06/2009. Afterwards, he continued with severe bilateral leg pain despite physical therapy and pain management. His neurological examination reveals weakness in the left tibialis anterior. An MRI of the lumbar spine 02/10/2010 reveals postoperative changes at L3-L4. At L4-L5 there is a mild disc bulge with mild spinal stenosis and mild right lateral recess stenosis. At L5-S1 there is minimal diffuse disc bulge and facet hypertrophy with mild spinal stenosis. He has achieved psychological clearance for the procedure. He received at least 70% improvement from a spinal cord stimulation trial.

### ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The Lumbar laminectomy with insertion of the paddle electrode and SCS implantation is medically necessary. The claimant has failed back syndrome and does not have a surgical lesion. He has failed other, reasonable conservative measures. He had a successful spinal cord stimulator trial. He meets the ODG criteria. The reviewer finds that medical necessity does exist for Lumbar laminectomy with insertion of the paddle electrode and SCS

implantation.

## References/Guidelines

2010 Official Disability Guidelines, 15th edition

“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.

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

ACOEM-AMERICA 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)