



Specialty Independent Review Organization
Notice of Independent Review Decision

DATE OF REVIEW: 12/7/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a percutaneous implantation of neurostimulator electrode array, epidural.

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. The reviewer has been practicing for greater than 15 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 disagrees with the previous adverse determination regarding prospective medical necessity of a percutaneous implantation of neurostimulator electrode array, epidural.

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):

Records reviewed from Dr.: 10/22/10 to 11/2/10 letters, RN, ANP, office notes by Nurse 1/27/10 to 10/21/10, office notes by Dr. 5/25/10 to 7/19/10, 7/20/10 notes, RN FNP and 4/8/10 to 8/26/10 operative reports.

LM: 11/18/10 letter by, 10/12/1 denial letter, 11/1/10 denial letter, 10/12/10 report 11/1/10 report 11/16/10 request for IRO, 10/7/10 preauth request, 2/21/05 reports by Dr. 4/28/10 pre-surgical behavioral evaluation, letter of clarification DO, 10/27/10 preauth request,

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured when at work. He has cervical and lumbar injuries. He has undergone cervical ACDIF. He has undergone LESI. A SCS trial was attempted. Documentation indicates improvement in back and left leg symptoms by 60%, increased stance time for chores and ambulation, and better sleep. No documentation in use of analgesics is offered for review.

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

ODG 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.).

This criterion is met.

(2) psychological clearance indicates realistic expectations and clearance for the procedure.

This criterion is met.

(3) there is no current evidence of substance abuse issues. **This criterion is met. He has passed random urine drug screens, he is off methadone.**

(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.

This criterion is met. He has passed random urine drug screens prior to SCS implantation. He still required analgesic medication, but eh note on 9/2/10 at Pinnacle indicates that this is for co-existing neck pain which the SCS will not help.

Given that the criteria for lumbar SCS implantation per the ODG have been met, the requested treatment is medically necessary.

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)