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Notice of Independent Review Decision

DATE OF REVIEW: 1/8/10

IRO CASE #:

Description of the Service or Services In Dispute
Trial spinal cord stimulator

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

Physician Board certified in Neurological Surgery

REVIEW OUTCOME

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

Upheld	(Agree)
X Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

Description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse determination letters, 11/6/09, 11/25/09
Psychological clinic report 10/26/09
Clinical notes, 2009, Dr.
Report 9/19/09, Dr.
Letter 3/16/09, Dr.
2/22/08 Progress notes, Dr.
10/26/07 Report, Dr.
Lumbar MRI report 11/11/08, 4/27/07
Cervical MRI report 3/13/06
Lumbar spine x-ray 7/14/05
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who in xxxx was carrying files and tripped over additional files and developed low back, neck and right shoulder pain. The neck pain was soon joined by left upper extremity pain, and despite medications and physical therapy, this pain continued. MRI showed C5-6 and C6-7 difficulties on the left side, suggesting a reason for her trouble, and an ACDF was performed at the C5-6 and C6-7 levels on 7/31/96. Right shoulder pain continued and right shoulder surgery was performed in 1997. Neck pain continued and a pseudoarthrosis was found on the patient's cervical spine, and a repeat fusion was carried out in 1999 at the C5-6 and C6-7 levels. More right shoulder surgery was performed in 2000 because of continued trouble and an additional fall, which aggravated the problem. There was pain primarily in her neck during the first five years after the 1996 injury, but some

back pain was present, which became more severe. Evaluation suggested L5-S1 disk herniation, and two surgeries were performed in 2001 because of recurrent disk herniation. This level was heavily dealt with anterior and posterior approaches with fusion, decompression and instrumentation in 2005, but the patient continues to have pain in her low back and into her left lower extremity. She intermittently reports neck pain, but this is a minor problem compared to the low back and left lower extremity pain. She has had a morphine pump, which was discontinued because of irritation secondary to the implant. Psychological testing on 10/26/09 indicated no significant psychological contraindication to spinal cord stimulation. The patient indicates that she had a trial of spinal cord stimulation which was probably helpful, but the apparatus became disconnected and needs to be re-implanted to make sure that it is of benefit to the point that a permanent stimulator would be indicated..

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

I disagree with the decision to deny the proposed trial spinal cord stimulator. The patient's pain is primarily back and left lower extremity pain at this time, and an initial trial was somewhat helpful, but was not present long enough for it to be truly indicative of a permanent trial cord stimulator placement. Recent psychological evaluation indicates no significant psychological contraindications for spinal cord stimulation.

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
- AHCP- 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)