

Notice of Independent Review Decision

April 27, 2010 **Amended Date: May 3, 2010**

DATE OF REVIEW: APRIL 27, 2010 **AMENDED DATE:** MAY 3, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

A dispute has occurred in regards to the medical necessity of a spinal cord stimulator.

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

This physician is a Board Certified Neurological Surgery with 43 years of experience as a neurosurgeon, a Fellow with American College of Surgeons, a member of American Board of Neurological Surgery, and a member of American Association of Neurological Surgeons.

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)

Provide a 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

On xx/xx/xx, Mr. underwent a FCE at Accident and Injury Rehab. Mr. tested in the Sedentary Physical Demand Level.

On September 24, 2009, M.D. evaluated the examinee. Dr. noted that the examinee was ambulating with the use of a cane. Diagnosis: Post-traumatic lumbar disk pathology with mainly a chronic mechanical low back disorder and right lumbar radiculopathy. Recommendations: Lumbar myelogram and CT scan.

On January 5, 2010, M.D. performed a Lumbar myelogram on the examinee. Findings: Mild anterior extradural defects are present at L2-3 and L3-4 levels. No nerve root amputations noted. Lumbar myelogram otherwise unremarkable.

On January 5, 2010, Lumbar CT postmyelogram with intrathecal contrast was performed, read by M.D. Findings: L2-3 disk space: Mild broad-based bulging of the disk noted causing mild encroachment upon the anterior aspect dural sac and neural foramina. Facet joint laxity noted. Thickening of the ligamentum flavum noted posteriorly. The findings cause mild spinal canal stenosis and mild bilateral neural foraminal stenosis. L3-4 disk space: Minimal broad-base bulging of the disk noted causing minimal encroachment upon the anterior aspect dural sac. Neural foramina and facet joints are maintained. L4-5 disk space: Disk, dural sac, and neural foramina are maintained. Mild degenerative changes are present involving the facet joints. L5-S1 disk space: Gas is present within the disk. There is mild broad-based bulging of the disk noted causing mild encroachment upon the anterior aspect dural sac and neural foramina. Degenerative changes are present involving the facet joints, however, no significant facet hypertrophy noted. CT evaluation lumbar spine obtained postmyelogram is otherwise unremarkable.

On February 5, 2010, PhD evaluated the examinee. Impression: Pain disorder associated with both psychological factors and work related injury. Lumbar intervertebral disc without myelopathy.

On February 17, 2010, D.C. evaluated the examinee. Diagnosis: Lumbar pain, stiffness, and weakness. The examinee presented in the Sedentary PDL Category.

On February 18, 2010, M.D. re-examined the examinee and recommended trial spinal cord stimulator.

On February 25, 2010, M.D. performed an Utilization Review Decision on Mr. Decision: The examinee does not meet the criteria for spinal cord stimulator as the examinee does not appear to have undergone at least one previous back surgery. The examinee does not fall in the CRPS category or other categories to support this device.

On March 25, 2010, M.D., a neurosurgeon, performed an Utilization Review Decision on Mr.. Decision: The indications for spinal cord stimulator are failed back syndrome defined as persistent pain in patients who have undergone at least one previous back operation and are not candidates for repeat surgery, complex regional pain syndrome, post-amputation pain, post herpetic neuralgia, spinal cord injury, pain with multiple sclerosis or peripheral vascular disease causing pain. Therefore, in review of this claimant's record, medical necessity for spinal cord stimulator trial is not established.

PATIENT CLINICAL HISTORY:

Per Dr. report the examinee was lifting a heavy fan and had the sudden onset of severe low back pain with bilateral radiating hip & leg pain.

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

<p>Per the ODG Guidelines an examinee must have undergone at least one previous back operation and is not a candidate for repeat surgery to become a candidate for a spinal cord stimulator; therefore, the previous determinations are upheld. Spinal cord stimulators (SCS)</p>	<p>Indications for stimulator implantation:</p> <ul style="list-style-type: none"> • Failed back syndrome (<u>persistent pain in patients who have undergone at least one previous back operation and are not candidates for repeat surgery</u>), 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. • Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), 70-90% success rate, at 14 to 41 months after surgery. (Note: This is a controversial diagnosis.) • Post amputation pain (phantom limb pain), 68% success rate (Deer, 2001) • Post herpetic neuralgia, 90% success rate (Deer, 2001) • Spinal cord injury dyesthesias (pain in lower extremities associated with spinal cord injury) • Pain associated with multiple sclerosis • Peripheral vascular disease (insufficient blood flow to the lower extremity, causing pain and placing it at risk for amputation), 80% success at avoiding the need for amputation when the initial implant trial was successful. The data is also very strong for angina. (Flotte, 2004)
---	---

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)