

SENT VIA EMAIL OR FAX ON
Aug/17/2011

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Spinal Cord Stimulator

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

D.O., Board Certified Neurosurgery

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

OD Guidelines

1. Cover sheet and working documents
2. Report of medical evaluation 05/30/06
3. MMI and impairment rating dated 07/26/06
4. MRI lumbar spine without and with contrast dated 09/17/09
5. Progress notes Dr. dated 12/08/09-06/07/11
6. Lumbar spine CT post discography dated 03/23/10
7. Designated doctor evaluation dated 04/22/10
8. MRI lumbar spine without contrast dated 02/09/11
9. Procedure note dated 03/21/11
10. Psychodiagnostic assessment dated 05/11/11
11. Activity summary notes dated 05/24/11
12. Utilization review for request spinal cord stimulator trial dated 05/25/11
13. Notice of utilization review dated 05/26/11
14. Utilization review for appeal request spinal cord stimulator dated 06/15/11
15. Notice of utilization review dated 06/17/11

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate he was injured when he slipped and fell in parking lot during an ice storm. The injured employee is status post multiple surgeries including L5-S1 IDET, L5-S1 decompression, and L5-S1 fusion. The injured employee continued to complain of low back pain radiating to bilateral lower extremities. He underwent bilateral L4-5 medial branch blocks on 02/14/11 with minimal improvement. On 03/21/11 bilateral L4-5 transforaminal epidural steroid injection was performed with short term relief. On 04/28/11 spinal cord stimulator trial was recommended. Per psychological evaluation dated 05/11/11 the injured employee was determined to be an appropriate candidate for spinal cord stimulation.

A preauthorization request for spinal cord stimulator trial was reviewed on 05/25/11 and determined as not medically necessary. It was noted in the latest report dated 04/28/11 the injured employee reported low back pain. Based on psychological evaluation dated 05/11/11, there were no contraindications to the proposed procedure from a psychological perspective. The injured employee had previous lumbar surgeries including fusion at L5-S1. There were no operative reports submitted for review which define the extent and details of previous surgical interventions. In addition, there was no clear documentation of formal rehabilitative efforts done for the injured employee following the surgeries. Records state the injured employee was rendered conservative treatment in the form of physical therapy, injections, work conditioning and medications. However, the records did not provide objective documentation of the injured employee's clinical and functional response following therapy. There was no clear indication that the injured employee had failed an optimized course of pharmacotherapy. While the latest report described the severity of symptoms at range of 41-89/100, the degree of pain was not further assessed in terms of activity logs, compliance with medications, and subjective documentation on degree of relief obtained. Hence medical necessity of the request was not established at this point.

An appeal request for spinal cord stimulator was reviewed on 06/15/11 and again determined as not medically necessary. In the latest report dated 06/07/11 it was noted that the injured employee reported continued axial low back pain aggravated by prolonged static positions. He reported it is alleviated with frequent position changes. It was noted that spinal cord stimulator has been requested and denied. As such, this is now being reconsidered. Based on the psychological evaluation dated 05/11/11, there were no contraindications to the proposed procedure from psychological perspective. The patient had previous lumbar surgeries including fusion at L5-S1, but there were no operative reports submitted for review which define extent and details of previous surgical interventions. In addition, there was no clear documentation of formal rehabilitative efforts done to the patient following these surgeries. Records indicate the claimant has had physical therapy, injections, work conditioning, and medications; however, the records do not provide objective documentation of the patient's clinical and functional response following therapy. It was noted the injured employee was recently instructed to discontinue therapy due to increasing pain. There is no clear indication that the injured employee had failed an optimized course of pharmacotherapy. While the latest report described the severity of symptoms at range of 26-93/100, prior to this it was noted to be 41-89/100. The degree of pain was not further assessed in terms of activity logs, compliance to medications, and subjective documentation on degree of relief obtained. The injured employee reported he takes Tramadol on occasion but is unwilling to take additional medications due to fear of becoming addicted. Medical necessity of the requested procedure is not established at this point.

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

Based on the clinical information provided, medical necessity is not established for the proposed spinal cord stimulator trial. The injured employee is status post L5-S1 fusion. Records indicate the injured employee has failed to improve with physical therapy,

medications, injections, and work conditioning. The most recent assessment noted axial lumbosacral pain originating in the L2-3 segment. Spinal cord stimulator is not indicated for axial back pain. Further assessment indicates adjacent segment degeneration at L4-5 with retrolisthesis and severe facet joint hypertrophy and sclerosis and central canal stenosis. The injured employee was noted to have had excellent diagnostic relief from bilateral L4-5 transforaminal epidural steroid injections performed 03/21/11. The injured employee reportedly has rapidly developing proximal muscle weakness in lower extremities and decreased walking tolerance and climbing stairs with increased heaviness, numbness, and pain in lower extremities. It appears the injured employee has adjacent segment disease and may be a surgical candidate. Per ODG guidelines, spinal cord stimulator implantation may be indicated for failed back syndrome in patients with persistent pain who have undergone at least one previous back operation and are not candidates for repeat surgery. In this case it appears the injured employee may well be a candidate for further surgical intervention. The guidelines further reflect that all of the following should be present: 1) symptoms primarily lower extremity radicular pain with limited response to non-interventional care. Again, in this case, the injured employee had significant response to epidural steroid injections at L4-5 level, which is diagnostic that the L4-5 level is the generator of radicular pain. Given the current clinical data, spinal cord stimulator trial is not indicated as medically necessary.

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)