

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: February 21, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Trial spinal cord stimulator under fluoroscopy with IV sedation

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

The physician reviewer is duly licensed to practice medicine in the state of Texas. The reviewer is fellowship trained in pain management and board certified by the American Board of Anesthesiology with certificate of qualifications in pain management. The physician reviewer has over 23 years in the active and current proactive pain management.

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant was alleged injured in xxxx stating injuries to his neck and posterior of left shoulder. He subsequently underwent multilevel cervical fusion in 2008. Cervical CT scan in 2008, demonstrated anterior cervical interbody fusion from C4 through C7, with the suggestion of a posterior C3-C4 disc protrusion, but no definitive evidence of spinal cord or nerve root compression. Cervical MRI was recommended.

One year later, in 2009, cervical MRI was performed demonstrating a medium central C3-C4 disc protrusion with no foraminal or canal stenosis and left C6-C7 posterior osteophytes impinging on the left C7 nerve root.

In 2010, the claimant was seen by for continued management of medications which, at the time, were Lortab 10 q.i.d., Flexeril 10 mg t.i.d., and Lunesta 3 mg

h.s. The claimant's pain level was said to be 3 on medication, 7 without.

An unknown chiropractor evaluated the claimant in 2010, for continuing posterior neck and posterior left shoulder pain. The chiropractor documented the claimant's pain level as ranging from 4-8/10, and recommended "rest, ice, compression, and elevation".

In 2010, cervical x-rays were performed at the request of physician demonstrating evidence of C4-C5 through C6-C7 fusion with mild facet degeneration above the fusion.

Physician followed up with the claimant in 2010, noting that a recommended CT myelogram had been denied three times. The claimant reported "no significant improvement" with continued "stabbing pain with radiation of a shooting pain into the left upper extremity along the lateral arm and into the first three fingers of the left hand", with a pain level was 7-8/10. Physical exam documented mild decreased strength and reflexes in the left triceps with a bilateral positive Spurling's test. Given the claimant's complaint of unilateral pain, a bilateral cervical Spurling's test being positive would be of no clinical validity.

Dr. recommended a chronic pain management program and consideration of a spinal cord stimulator. He referred the claimant to another Dr. for initial evaluation in 2010. This Dr. documented the claimant's complaints of neck and bilateral shoulder and upper arm pain with numbness and weakness. There had never been any previous mention of bilateral upper extremity symptoms. Dr. noted the claimant has undergone discectomy and fusion in 2008, with pain that was said to be "worse ever" and a pain level of 7-8/10. Dr. administered a "pain related stress inventory" to the claimant which was suggestive of a "moderate-to-severe reactive depression and anxiety".

Physical exam documented decreased bilateral neck rotation with moderate interspinous cervical tenderness and non-specific tenderness throughout all the muscles of the neck, head, and upper back. A mildly decreased left C5-C6, pinprick sensation was noted, with normal grip strength bilaterally. Pinprick sensation was said to be diminished "non segmental dermatomal fashion". Dr. diagnosed the claimant with post cervical laminectomy pain syndrome, generalized deconditioning and chronic myofascial pain, recommending discontinuation of the use of skeletal muscle relaxant, but institution of Cymbalta 60 mg a.m. and clonazepam at night. He also continued the claimant on hydrocodone, four times daily and recommended cervical epidural steroid injection via a catheter and consideration of a spinal cord stimulator.

In 2010, Dr. performed a catheter directed epidural steroid injection. He followed up with the claimant two weeks later, documenting a "more than 70%" sustained relief of pain. He noted the claimant still had "refractory depression" and recommended increasing Cymbalta to 60 mg daily while continuing Klonopin h.s., He recommended two more cervical epidural steroid injections. Seventeen days later, the unknown chiropractor evaluated the claimant, reporting absolutely no change in the claimant's prior complaints, pain level or exam. He then prescribed the same passive modalities treatment. Eleven days later, Dr. followed up with the claimant again stating the claimant had "over 70% relief" following the epidural steroid injection, which is a significant contradiction to what

the chiropractor had documented only eleven days before, which was no change in the claimant's pain complaints or pain level. Dr. again recommended two more cervical epidural steroid injections and noted the claimant's Norco use had decreased to only two or three times daily.

Three weeks later, Dr. followed up with the claimant now stating that the claimant had "failed all prior treatments", contradicting his own previous documentation of greater than 70% relief from cervical epidural steroid injections. He now recommended a spinal cord stimulator trial. Two days later, the same chiropractor as before evaluated the claimant noting that the claimant was in "relative comfort" and that his pain level was only 3-4/10. Physical exam documented non specific decreased range of motion, muscle spasm and tenderness.

In 2010, a "psychologic evaluation to assess psychological risk factors associated with poor outcome for implantable pain therapy" was performed by an L.P.C. She noted the claimant had completed four weeks of a work hardening program, including four sessions of once weekly counseling associated with the program. The claimant's complaint was stated to be "upper back radiating to his lower back" with no mention whatsoever of upper extremity symptoms. The claimant's pain level was said to be 7-8/10. The psychological evaluation documented the claimant's complaint of symptoms common to depression and anxiety with "markedly" preoccupation with physical and functional losses. Psychologic testing was also performed. The Beck depression inventory score of 36 indicated the claimant suffering from a "severe level of depression". The Beck Anxiety Inventory Score of 26 also indicated the claimant suffering "severe level of symptoms of anxiety". MMPI-2 testing was also performed demonstrating elevations in clinical scales "consistent with an individual experiencing significant depression, tension, worry, foreboding, obsession and intrusive thoughts". Based upon the psychologic testing, the claimant was said to have "tendency to focus on physical concerns rather than addressing the accompanying emotional issues" and was likely to lack insight into the connection between emotional distress and physical functioning. The evaluation documented the claimant's hope to obtain a reduction in his pain score from "7-8/10 to 6/10" far below the 70% response that Dr. stated would be necessary to proceed with a permanent implantation. The claimant also stated that he felt he did not have sufficient understanding of the procedure or the risks of the procedure, or how the spinal cord stimulator would "affect him". Based upon the entirety of the evaluation, L.P.C. noted the claimant was continuing to experience severe depression despite taking Cymbalta and stated that Cymbalta was not producing a desired therapeutic response, recommending consideration to increase the dose or begin another antidepressant. She stated that the claimant "would not be an ideal candidate for SCS presently" and that a "trial of psychotherapy" was necessary for four weeks, one session per week followed by re-administration of psychologic testing to see if the claimant had improved.

Approximately three weeks later, Dr. followed up with the claimant. Despite the clear recommendation of the psychologist against consideration for spinal cord stimulation, and the clear diagnosis of "major depressive disorder" that was made, Dr. stated that "there is no major depression or personality disorder which would preclude a satisfactory outcome" from spinal cord stimulation. Clearly this opinion cannot be supported by the clear documentation of the psychologic

evaluation to the contrary. Dr. also noted the claimant had increased Norco to four times per day, which is exactly the same dose that he was on when Dr. first treated him, a dose which Dr. fully supported.

Initial review by physician advisor recommended non-authorization of the requested spinal cord stimulator trial.

In January 2011, Dr. wrote a letter requesting reconsideration, providing no new medical information, only a criticism of the physician advisor's opinion.

A second separate physician advisor reviewed the request in January 2011, also recommending non-authorization based upon the psychologic evaluation revealing significant evidence of depression and a clear recommendation against the spinal cord stimulator trial. The physician advisor noted that he had spoken with Dr. regarding the case who stated "the psychologist's only role is to rule out major depression which would preclude a satisfactory outcome, not to recommend a spinal cord stimulator". In fact, this is exactly what the psychologist did, diagnosing a major depressive disorder and recommending against spinal cord stimulation trial.

In January 2011, Dr. followed up with the claimant noting that the claimant was "dejected and despondent" and significantly preoccupied with things. Dr. recommended IRO review and increased the claimant's Norco to 20 mg t.i.d. He also noted the claimant was taking Cymbalta 60 mg b.i.d. and "recommended psychologic counseling".

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

According to ODG, and nationally accepted standards of care and indications for the use of spinal cord stimulation, spinal cord stimulation is a reasonably effective therapy for patient's suffering from neuropathic pain "for which there is no alternative therapy". ODG guidelines also recommend psychologic screening prior to all spinal cord stimulator implantation. This claimant has not exhausted all appropriate treatment for neuropathic pain. In fact, other than narcotics and antidepressants, there is no evidence of this claimant undergoing a trial of neuropathic pain medication such as gabapentin or Lyrica, medications which are recommended by ODG for neuropathic pain and which are often very effective for its treatment. Additionally, the claimant apparently had a sustained significant clinical benefit from an epidural steroid injection performed by Dr., but no further cervical epidural steroid injections were performed. ODG treatment guidelines would certainly support repeating the cervical epidural steroid injection which truly provided the "70%" relief documented by Dr. for well over one month. Finally, the psychologic evaluation that was performed on this claimant at the request of Dr. quite very clearly documented this claimant as having a major depressive disorder, and recommended and clearly stated that the claimant was NOT an appropriate candidate for spinal cord stimulation. A recommendation was made for four weekly sessions of individual psychotherapy, in fact, Dr. also recommended for this claimant in his last progress note. Therefore, according to ODG treatment guidelines and the entirety of the records provided for this review, the only logical conclusion that can be reached is that

this claimant is not an appropriate candidate for spinal cord stimulation according to ODG treatment guidelines, nationally accepted treatment guidelines and indications for spinal cord stimulation, and perhaps, most importantly, the clear evidence of significant depression and recommendation against spinal cord stimulation trial provided in the psychologic evaluation requested by Dr.. Therefore, the recommendations of the two previous physician advisors for non-authorization of the request for trial spinal cord stimulation with fluoroscopy and IV sedation are upheld. The requested procedure is not medically reasonable or necessary, and is not appropriate for this claimant as related to the work injury herein under review.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**