

**AccuReview**  
An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW:** February 2, 2011 **Amended Date:** February 3, 2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Percutaneous Implantation of Neurostimulator Electrode Array, Epidural

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

This physician is a Board Certified Physical Medicine and Rehabilitation Physician with 15 years of experience.

**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 June 14, 2005, an MRI/MRA of the brain was performed. Impression: Normal MRI of the brain as interpreted by M.D.

On June 14, 2005, a CT of the head was performed. Impression: No acute intracranial process as interpreted by M.D.

On August 6, 2010, the claimant was evaluated by M.D. He reports severe persistent headaches. Cymbalta did not make his symptoms better and worsened over the past month. Verapamil also did not seem to help. He does have cervical and upper thoracic musculature tightness and trigger points. Impression: Posttraumatic headaches. Dr. changed his medications to Cymbalta 30mg, Klonopin .5 mg, Phenegran 25 mg and Ultram 50 mg. A consultation by a headache specialist was recommended.

On October 18, 2010, the claimant was evaluated by D.O. Chief complaint is neck pain. He had injections which did not help. He later underwent surgical fusion, from 1995-2002 he had 3 neck surgeries. He returned to work after each surgery. He was placed on disability in February 2009. He tried cervical medial branch blocks without success. In August 2009 he went through a month of physical therapy. The pain radiates intermittently into both hands, left greater than right. He admits to daily headaches which are often worse than the neck pain. Neck Examination: Decreased ROM. Diffused cervical tenderness to palpation. Negative Spurling maneuver bilaterally. Back Examination: ROM full. Normal paraspinal tone. Negative SLR seated and supine. Impression: Failed neck syndrome, cervical radiculitis, and cervicgia. Botox for the headaches and a spinal cord stimulator for the neck were recommended.

On November 9, 2010, the claimant was evaluated re-evaluated by, D.O. He is doing the same since the last visit. He is very interested in the spinal cord stimulator. He admits to numbness in the left hand. New medications: Baclofen 10 mg and Clonazepam .5 mg.

On November 22, 2010, the claimant was evaluated by D.O. He is there for a consultation for a cervical spinal cord stimulator trial. A recent CT Myelogram demonstrates no central canal stenosis at any level. X-rays of the cervical spine were recommended. Medications: Cymbalta. Promethazine. Clonazepam. Baclofen. Physical Examination: Motor Strength 5/5 at the deltoid, biceps, triceps, and forearm. He has some subjective weakness in the arms and the legs. Assessment: The claimant is apparently failed several sessions of therapy as well as injections. He cannot tolerate the lot of different pain medications and he is on a reasonable regimen of medications right now and it does not seem to be controlling his pain to allow him to at least conduct his activities of daily living. I think it would be reasonable to consider the cervical stimulator trial to see if he might get some relief.

On December 9, 2010, the claimant was re-evaluated by D.O. He has been trying to taper off Clonazepam. His pain is the same as the last visit. Again a spinal cord stimulator was recommended. Assessment: Failed neck surgery syndrome. Cervical Radiculitis. Cervicgia.

On December 22, 2010, M.D., an anesthesiology and pain management physician performed a utilization review on the claimant. Rationale for denial: The patient should have psychological clearance and the patient has had limited response to non-interventional care. It is unclear as to whether the patient has gone through appropriate interventional care prior to the trial. Therefore it is not certified.

On January 11, 2011, D.O., a physical medicine and rehabilitation physician performed a utilization review on the claimant. Rationale for denial: There is no documentation that any specific psychological evaluation has been completed to determine whether the patient is an appropriate candidate or not. There was also no indication as to whether any other lower levels of care have been attempted such as individual psychotherapy or a chronic pain management program to address the patient's pain coping skill. Therefore it is not certified.

### **PATIENT CLINICAL HISTORY:**

In xxxx the claimant sustained an injury to the neck when the truck doors had frozen shut and he was struggling to get the doors open.

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

Decision to deny cervical spinal cord stimulator is upheld. Per the ODG Pain Chapter, under Failed Back Syndrome for Spinal Cord Stimulator, submitted clinical records do not indicate whether the claimant has exhausted lower levels of care such as chronic pain management or whether he has had psychological clearance for the procedure. Therefore, based on the ODG Guidelines the previous decisions are upheld.

### **ODG Guidelines:**

#### **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.); (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 dysesthesias (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)