

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Trial spinal cord stimulator with Fluoro & Mac anesthesia of lumbar spine

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

M.D., Board Certified Orthopedic Surgeon

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

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates, chapter low back, psychological testing and pain chapter,

Electromyography report 08/23/09

10/08/09, 01/14/10 operative reports

11/24/10 psychological evaluation

Records of NP, 12/15/10, 01/21/11, 02/20/11, 03/21/11, 04/11/11, 04/25/11

Peer reviews 03/21/11, 03/30/11

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury of xx/xx/xx. Diagnosis was status post lumbar fusion L5-S1 in 2004. The claimant has chronic low back pain and bilateral lower extremity pain, left worse than the right. The 11/24/10 psychological evaluation deemed the claimant an acceptable candidate for the spinal cord stimulator. Review of the records indicated that the claimant has been treated with medications, narcotics, epidural steroid injection, sacroiliac joint injections, TENS, and physical therapy. It was noted that the claimant was having issues with the medications.

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

The requested trial spinal cord stimulator with Fluoro & Mac anesthesia of lumbar spine is medically necessary based on review of this medical record. This is a gentleman who has had ongoing back and radicular leg complaints following a xxxx injury. The medical records for review document an EMG with some radicular issues on the left. The claimant has had epidural steroid injections without good long-term improvement and had a November 2010 psychologic evaluation for spinal cord stimulation, which found him to be an acceptable candidate for the procedure. On 12/15/10, he was seen by Dr. pain management, and there were further medical records following that documenting his complaints and findings. Dr. records document failure of appropriate conservative care to include a transcutaneous

electrical nerve stimulation (TENS) unit, medication, stretching, therapy, and home exercises, as well as epidural steroid injection, fusion surgery, and multiple medications. These records indicate that he has issues with medication, and they would like to perform spinal cord stimulation trial. Official Disability Guidelines document the use of a spinal cord stimulator trial in patients who have chronic back and radicular leg complaints who have failed previous care, have no further indication for surgery, and have cleared psychologic evaluation. All of that appears present in this case. Therefore, the reviewer finds that Trial spinal cord stimulator with Fluoro & Mac anesthesia of lumbar spine is medically necessary. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates, chapter low back, psychological testing and pain chapter,

Recommended pre intrathecal drug delivery systems (IDDS) and spinal cord stimulator (SCS) trial

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.

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)