

# Wren Systems

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Apr/30/2011

**IRO CASE #:**

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

Dorsal column stimulator permanent implant, thoracic ANS 63655 63685 95972 with equipment codes L8680 x 16 L8681 L8687 L8689

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

MD, Board Certified Neurosurgeon

**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**

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male with a date of injury xx/xx/xxxx. He is status post L4-L5 lumbar laminectomy 01/20/2010 and continued with low back and leg pain with numbness. He has undergone physical therapy. He is on chronic pain medications. His neurological examination reveals decreased sensation in the top and side of his foot on the left. Electrodiagnostic studies 09/08/2010 show chronic radiculopathy at L5. An MRI of the lumbar spine 06/28/2010 shows postsurgical changes with no residual or recurrent herniation. A psychological evaluation found him to be a good candidate for the dorsal column stimulator. He underwent a dorsal column stimulator trial 12/21/2010 and obtained 80-90% relief, with decreased pain medication and improvement in ADLs.

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

The Dorsal column stimulator permanent implant, thoracic ANS 63655 63685 95972 with equipment codes L8680 x 16 L8681 L8687 L8689 is medically necessary. The claimant has undergone and failed conservative measures. He no longer has a surgical lesion and has failed back syndrome with persistent radiculopathy. He had excellent pain relief with the spinal cord stimulator trial with improvement in daily function. He is psychologically cleared

for the procedure. His condition meets the ODG criteria for placement of a spinal cord stimulator. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

2011 Official Disability Guidelines, 16th edition, "Pain" chapter: 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.

**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)