

SENT VIA EMAIL OR FAX ON  
May/25/2012

## True Decisions Inc.

An Independent Review Organization  
2002 Guadalupe St, Ste A PMB 315  
Austin, TX 78705  
Phone: (512) 879-6332  
Fax: (214) 594-8608  
Email: rm@truedecisions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/22/2012

**IRO CASE #:**

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

Spinal Cord Stimulator Trial

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

Anesthesiology/Pain Management

**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

Notification of adverse determination 03/30/12

Notification of reconsideration determination 04/27/12

Designated doctor evaluation 01/18/12

Request prior authorization 04/10/12

Appeal/reconsideration

Initial evaluation and office notes Dr. 02/02/12 and 03/21/12

Procedure report left transforaminal epidural steroid injection L5, S1 02/27/12

Upright MRI lumbar spine 03/11/11

MRI cervical spine 01/16/12

X-rays lumbar spine 12/14/10 and 05/28/10

Acknowledgement of reconsideration request 04/13/12

Disability determination services request for additional information 03/27/12

Notification of medical necessity/unresolved dispute 02/09/12

## **PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male whose date of injury is xx/xx/xx. Records indicate he was injured when he fell backwards off of a platform on to his back. Per initial evaluation dated 02/02/12 the claimant has undergone physical therapy as well as lumbar epidural steroid injection in 11/11 which the claimant states lasted about two months with about 70% relief. Physical examination reported 5/5 strength in the bilateral lower extremities. Straight leg raise was positive on the left. Deep tendon reflexes were 1 on the right, 0 on the left. Sensation was decreased on the left lower extremity in the L4-5 and L5-S1 distribution. The claimant was recommended to undergo repeat epidural steroid injection. The claimant was seen in follow-up on 03/21/12 and was noted to have undergone left transforaminal lumbar epidural steroid injection at L5 and S1 performed 02/27/12 in which the claimant does not report any improvement in symptoms. It was noted that the claimant continues to have severe pain in the lower back with radiation down the left lower extremity. He did not receive any improvement from left transforaminal lumbar injection. He was not believed to be a good candidate for lumbar spinal surgery due to multiple levels involved that have moderate to severe pathology. A surgical undertaking would most likely involved a 3-4 level fusion for which he most likely would continue to suffer with chronic pain. The claimant was recommended to undergo spinal cord stimulator.

A pre-authorization request for spinal cord stimulator trial was reviewed on 03/30/12 and the request was non-certified. It was noted that the latest medical report dated 03/21/12 states the claimant continues to experience moderate to severe pain in the lower back with radiation down the left lower extremity, 7/10 in severity. Physical examination showed decreased lumbar lordosis, limited lumbar extension and flexion with pain, facet tenderness at the bilateral L4-5 and L5-S1, and 4/5 motor strength on the right at L4, L5 and S1. Although guidelines recommend the employment of spinal cord stimulators for patients with chronic pain syndrome, the spinal cord stimulator is typically recommended for patients with failed back syndrome or CRPS. Given that the claimant was also shown to have responded well to at least two epidural steroid injections it is uncertain why the claimant is not a candidate for surgery. Finally the results of prior psychological clearance if done are not available. As such medical necessity has not been established.

A reconsideration request was reviewed on 04/27/12 and was determined as non-certified. It was noted that the medical report dated 03/21/12 indicates the claimant continues to experience moderate to severe pain in the lower back with radiation down the left lower extremity. Physical examination showed decreased lumbar lordosis, limited lumbar extension and flexion with pain, facet tenderness at the bilateral L4-5 and L5-S1, and 4/5 motor strength on the right at L4, L5 and S1. It was noted that the medical reports provided still did not objectively document exhaustion of other less invasive conservative treatments such as oral pain medications and physical therapy. The functional objective patient responses through VAS pain scales and physical therapy progress notes were not provided. Contraindications to such a procedure were not noted. The psychological evaluation for the procedure was still not submitted for review. Hence the previous non-certification of the request is upheld.

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

The request for spinal cord stimulator trial is not supported as medically necessary based on the clinical data provided. The claimant is noted to have sustained an injury secondary to a fall on xx/xx/xx. He complains of low back pain radiating to the left lower extremity. The claimant was treated with medications, physical therapy and lumbar epidural steroid injections. First epidural steroid injection was noted to have provided approximately 70% relief lasting about two months. A second epidural steroid injection performed 02/27/12 was noted as not providing any improvement in symptoms. The claimant does not meet Official Disability Guidelines criteria for spinal cord stimulation. Per Official Disability Guidelines, spinal cord stimulators are recommended only for selected patients for whom less invasive procedures have failed or are contraindicated for specific conditions. As noted on previous reviews there is no indication that the claimant has exhausted all less invasive procedures or that such procedures are contraindicated. Moreover the guidelines indicated that spinal cord

stimulator is indicated for failed back surgery syndrome and complex regional pain syndrome (CRPS), and other conditions not relevant to this case. No psychological evaluation was provided documenting that the claimant is an appropriate candidate for spinal cord stimulator. Noting that the claimant has no history of previous lumbar surgery and is not diagnosed with CRPS, medical necessity is not established for spinal cord stimulator trial. As such the previous denials were correctly determined and are upheld on IRO.

**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)