True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Oct/09/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient permanent NeuroStim implant

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
PM&R and Pain Medicine

REVIEW OUTCOME:

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

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
MRI lumbar spine dated 11/16/07
Radiographic report dated 03/08/10
Procedure report dated 09/09/10
Procedure report dated 09/16/10
Peer review report dated 03/25/11
Follow-up notes Dr. dated 08/08/11
Preauthorization request dated 10/25/11
Behavioral medicine evaluation dated 11/02/11
Radiographic report lumbar spine dated 11/17/11
Office visit note Dr. dated 01/18/12-09/17/12
Radiographic report lumbar spine 2 views dated 06/01/12
Preauthorization report dated 07/09/12
Procedure report dated 08/15/12
Preauthorization request dated 08/21/12
Preauthorization report dated 08/22/12
Utilization review determination dated 08/27/12
Preauthorization report dated 08/29/12
Utilization review determination dated 09/05/12
Prospective review (M2) response dated 09/21/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant's date of injury is xx/xx/xx. The records indicate that he fell onto his right knee and shoulder. The records indicate that the claimant is status post ACDF C4-6, artificial disc replacement L4-5 and L5-S1, and artificial disc replacement C6-7. Claimant also was diagnosed with CRPS/RSD to the left lower extremity. Sympathetic block was performed 09/16/10. Claimant was recommended to undergo spinal cord stimulator trial. Behavioral medicine evaluation on 11/02/11 determined the claimant was clear for stimulator with a fair to good prognosis for pain reduction and functional improvement. Spinal nerve simulator trial was performed on 08/15/12. Progress note dated 08/20/12 noted that the claimant reports having over 75-80% relief with spinal cord simulator trial. It is noted that the stimulator has worked well covering his hip and leg pain. He has been able to increase his level of function. Claimant was recommended to undergo spinal cord stimulator permanent placement following the success of the trial. Claimant was seen for follow-up on 08/21/12. It was noted that the claimant had a one-week DCS trial with a Boston Scientific unit. He got over 70% relief from the device and was pleased with the outcome. He was unable to decrease his medication because of the dosing, but felt his symptoms were improved enough that if he continued on the device he would have been able to do without some of his medication.

A request for permanent neurostimulator implant was denied per pre-authorization review dated 08/22/12. The reviewer noted that per Official Disability Guidelines, the claimant should have failed back syndrome or symptoms of primary lower extremity radicular pain. There must be a psychological clearance indicating realistic expectations for the procedure. No concurrent evidence of substance abuse issues, and no contraindications to the trial. Permanent placement requires evidence of 50% pain relief and medication reduction or functional improvement after a temporary trial. Spinal cord stimulation is recommended for complex regional pain syndrome and reflex sympathetic dystrophy. Reviewer noted that documentation of other treatments for complex regional pain syndrome was not provided. A psychological evaluation specific to spinal cord stimulator implantation was also not provided. The request for permanent neurostimulator implant was not certified.

An appeal request for outpatient permanent neurostimulator implant was denied per pre-authorization review dated 08/29/12. The reviewer completed peer-to-peer with Dr.. The two reportedly had no disagreement. Despite reported 75-80% relief during trial, the pain level decreased from about 7 to 4 during trial (less than 50%) with no decrease in opiate use. Reviewer noted this is not indicative of a successful SCS trial and does not meet ODG criteria for implant. It was also noted that there was no documentation that any of the issues raised by psychological evaluation had been successfully treated or addressed, nor have adequate imaging studies to determine whether other surgical treatment options exist. Finally, the alleged RSD diagnosis is not supported by exam evidence.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the clinical data presented for review, the request for outpatient permanent neurostimulator implant is reported as medically necessary. The claimant reportedly was injured on xx/xx/xx. He has undergone multiple surgical procedures including ACDF, and artificial disc replacement in the lumbar and cervical spine. The records indicate that the claimant subsequently developed CRPS/RSD to the lower extremity. Although previous reviewer stated that there was no documentation of other treatment for RSD, there is a procedure note from sympathetic block to the lumbar spine for treatment of RSD of the lower extremity. Previous reviewer also noted that there was no psychological evaluation specifically addressing stimulator; however, per behavioral medicine evaluation dated 11/02/11, Dr. determined that, based on pre-surgical psychological screening, the claimant is clear for stimulator. Records indicate that the claimant obtained at least 50% pain relief following spinal cord stimulator trial performed on 08/16/12. This does meet ODG criteria. Records indicate that although the claimant did not reduce his medication because of the dosing, he felt symptoms were improved enough that if he had continued the device, he would have been able to reduce medication usage. He did note increased levels of function

and appropriate coverage of his hip and leg pain. As such, the request for permanent neurostimulator implant does meet ODG criteria, and the procedure is recommended as medically necessary.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)