

Notice of Independent Review Decision

September 12, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

In Office Spinal Cord Stimulator Trial for the Cervical and Lumbar Spines

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. The physician is certified in pain management. The physician is a member of the Texas Medical Board. The physician has a private practice of Physical Medicine & Rehabilitation, Electro Diagnostic Medicine & Pain Management in Texas. The physician has published in medical journals. The physician is a member of his state and national medical societies.

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Based on review of the information and documents provided for review, the denial is recommended to be upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received: 1 document received totaling 15 pages via fax 08/30/12 Texas Department of Insurance IRO request and Letter of authorization, 2 documents totaling 169 pages received via fax 09/04/12 URA response to disputed services including administrative and medical records. Dates of documents range from 08/04/04 to 08/30/12.

- TDI/DWC documentation submitted by the provider to support IRO request 08/28/12.
- Notice of Preauthorization Denial and Rationale for spinal cord simulator trial for the lumbar spine at Interventional Pain Management which resulted in a negotiated approval for MRI of the lumbar and thoracic spine with/without contrast granted by the physician advisor 07/12/12.

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25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-4443

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- Notice of Reconsideration of Preauthorization Denial and Rationale for spinal cord stimulator trial for the cervical and lumbar spine at Interventional Pain Management 07/25/12.
 - Determination Notice of Preauthorization Denial and Rationale for spinal cord stimulator trial for the lumbar spine as requested, which was based on the fact that there had not been a substantial change in the claimant's medical condition since the last review on 07/25/12 and 07/31/12.
 - Prior Notice of Preauthorization Denial and Rationale for re-trial spinal cord stimulator for the lumbar spine 04/12/12.
 - MRIs of the lumbar spine with and without contrast 12/22/10 and 07/17/12.
 - MRI of the thoracic spine with and without contrast 07/17/12.
 - Medical notes and operative reports for revision lumbar spine surgery at L5-S1 bilaterally and removal of EDI transmitter unit, 05/26/09 to 05/02/12.
 - Presurgical screening report 05/08/10.
 - Physical therapy progress notes 01/26/12 to 03/08/12.
 - Medical note 01/30/12.
 - Medical note 03/07/12 to 05/09/12.
 - Medical note 04/11/12.
 - Medical notes issued 02/09/12 to 07/17/12.
 - Presurgical screening and mental health testing report issued 06/21/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is indicated to have sustained injury involving the lower back as well as the neck area dating to xx/xx/xx. He has undergone multiple surgical interventions. The surgical interventions have included anterior cervical spine surgery with fusion from C3-4 through C6-7, anterior/posterior lumbar decompression and fusion at L4-5 as well as re-exploration and removal of a bone graft stimulator, and a prior placement of a spinal cord stimulator with removal secondary to infection.

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

The denial for the spinal cord stimulator trial is based on the *ODG* section concerning spinal cord stimulator implantation. Within the *ODG* and as noted below, there are several indications for spinal cord stimulator implantation. Reviewing the indications and following the instructions of the *ODG*, all of the following must be present for use of a spinal cord stimulator for persisting pain in failed back syndrome. Of the five required elements, it is noted that the patient has had psychological clearance, there is no current evidence of substance abuse issues, there is no identified contraindication to a trial, and the requirement for a certain percentage of response following a trial use of the stimulator is not applicable. However, the documentation indicates that one key element of the indications for spinal cord stimulator implant is not present, which is Item #1, symptoms are primarily lower extremity radicular pain, there has been limited response to non-interventional care such as neuroleptic agents, analgesics, injections, or physical therapy. The patient has primarily low back pain symptoms without radicular component.

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ODG Spinal Cord Stimulator Indications for Use

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.); **NOT PRESENT**
- (2) psychological clearance indicates realistic expectations and clearance for the procedure; **PRESENT**
- (3) there is no current evidence of substance abuse issues; **PRESENT**
- (4) there are no contraindications to a trial; **NONE IDENTIFIED**
- (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. **NOT APPLICABLE**

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)