

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311
Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jan/17/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

T9-10 Laminectomy Placement of Spinal Cord Stimulator

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

Neurosurgery

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)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI lumbar spine dated 04/13/10

Clinical notes dated 10/18/10, 12/02/10, 01/10/11, 06/24/11, 08/10/11, 09/21/11, 10/24/11, 04/26/12, 07/03/12, 07/18/12, 08/06/12, 09/19/12, 10/18/12, 10/22/12, 11/12/12, and 12/28/12

CT scan lumbar spine dated 11/19/12

CT scan lumbar spine dated 09/09/12

Spinal neurostimulator trial dated 10/12/12

Therapy notes dated 03/22/10 – 11/21/11

Previous utilization reviews dated 12/04/12 and 12/26/12

Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his low back. MRI of the lumbar spine

dated xx/xx/xx revealed degenerative disc disease at L4-5 with a central posterior disc protrusion resulting in mild canal stenosis and mild foraminal encroachment on the left. The clinical note dated 10/18/10 details the patient continuing with complaints of low back pain. The patient was noted to have positive straight leg raise on the left at 60 degrees and on the right at 45 degrees. Trace reflexes were noted at the knees and ankles. Pain was elicited on hip rotation. Hypoalgesia was noted down the lateral aspect of the distal right lower extremity and into the foot. Weakness was noted throughout the right foot, specifically in the right great toe on dorsiflexion. CT scan of the lumbar spine dated 11/19/10 revealed mild to moderate disc bulge at L4-5. The clinical note dated 12/02/10 details the patient continuing with weakness in both lateral feet, particularly with great toe dorsiflexion. Decreased sensation was noted in a L5 dermatome, specifically on the right. Per clinical note dated 01/10/11, the patient continued with low back pain complaints. The note details the patient having undergone a series of epidural steroid injections. The patient was noted to be ambulating with a flexed posture of the low back. Clinical note dated 06/24/11 details the patient utilizing Naproxen, Flexeril, Ultram, and Norco for ongoing pain relief. The clinical note dated 08/10/11 details the patient continuing with low back pain. The patient described an aching, burning, and "pins and needles" sensation. The patient rated the pain as 7/10 at that time. The patient was able to demonstrate 48 degrees of lumbar flexion, 10 degrees of extension, 12 degrees of right lateral bending, and 30 degrees of left lateral bending. Per clinical note dated 09/29/11, the patient stated that walking, standing, and activities exacerbated his pain. Per clinical note dated 10/24/11, the patient continued with numbness, dysesthesia, and weakness in the lower extremities. The therapy note dated 11/18/11 details the patient having completed 9 physical therapy sessions to date. The procedural note dated 04/26/12 details the patient undergoing an epidural steroid injection at an unknown level. The clinical note dated 07/03/12 details the patient rating his low back pain at 10/10. The clinical note dated 07/18/12 details the patient being recommended for a spinal cord stimulator trial. The patient was noted to have undergone a behavioral evaluation. The patient was noted to be motivated toward the procedure and was noted to have met a full endorsement from a psychological standpoint. The clinical note dated 08/06/12 details the patient continuing with a flexed posture when ambulating. The CT scan of the lumbar spine dated 09/09/12 revealed bilateral pars defects noted at L5-S1 with a mild disc bulge at L4-5. Degenerative changes were noted at the facet joints. The clinical note dated 09/19/12 details the patient having been approved for a spinal cord stimulator trial. The procedural note dated 10/12/12 details the patient undergoing a spinal neurostimulator trial. The clinical note dated 10/18/12 details the patient reporting 80% relief of pain with the spinal cord stimulator trial. The leads were subsequently removed. No additional medications were prescribed at that time. No evidence of erythema, edema, or purulence was noted upon removal of the leads. The patient stated that, during the trial, his pain level was 3/10. The clinical note dated 10/22/12 details the patient continuing with a radiculopathy component in the lower extremities manifested by weakness in both feet and decreased sensation in a L5 dermatome into the dorsum of the feet. The clinical note dated 11/12/12 details the patient rating his pain at 8/10. The patient described the pain as a stabbing, shooting, throbbing sensation.

The previous utilization review dated 12/04/12 resulted in a denial for a spinal cord stimulator implantation secondary to a lack of information regarding the patient's previous surgical interventions in the low back.

The utilization review dated 12/26/12 resulted in a denial secondary to a lack of reduction in the patient's use of pain medications or a functional improvement following the previous trial.

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

The request for a T9-10 laminectomy and placement of a spinal cord stimulator is certified. The documentation submitted for review elaborates the patient complaining of a long history of ongoing low back pain with a noted radiculopathy component in the lower extremities. The Official Disability Guidelines recommend permanent implantation of a spinal cord stimulator provided the patient meets specific criteria to include symptoms located primarily in the lower extremities, completion of a psychological evaluation, no history of substance abuse, and

50% pain relief and medication reduction throughout a previous spinal cord stimulator trial. The patient is noted to have completed all conservative measures to include the use of medications, injections, and physical therapy. The patient is noted to have an ongoing radiculopathy component manifested by strength and sensation deficits noted in the lower extremities. The patient did obtain psychological clearance (indicating realistic expectations of a spinal cord stimulator trial). The patient is noted to have experienced 80% reduction in pain with the use of a spinal cord stimulator. Additionally, the documentation does detail the patient reducing his pain medications throughout the trial. Given the patient's previous attempts at conservative measures, the ongoing radiculopathy component in the lower extremities, and the successful spinal cord stimulator trial, this request is medically necessary. As such, the documentation submitted for this review supports the request at this time.

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)