

**MAXIMUS Federal Services, Inc.**  
**4000 IH 35 South, (8th Floor) 850Q**  
**Austin, TX 78704**  
**Tel: 512-800-3515 ♦ Fax: 1-877-380-6702**

**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** May 17, 2013

**IRO CASE #:**

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

Outpatient 2 Lead Spinal Cord Stimulator (SCS) Trial (CPT Codes 63650, 95971, 72275.26 and 77003.26).

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

M.D., Board Certified in Orthopedic Surgery.

**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)

I have determined that the requested outpatient 2 Lead Spinal Cord Stimulator (SCS) Trial (CPT Codes 63650, 95971, 72275.26 and 77003.26) is not medically necessary for treatment of the patient's medical condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 4/25/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/26/13.
3. Notice of Assignment of Independent Review Organization dated 4/29/13.
4. Denial documentation dated 2/15/13, 3/13/13, 4/17/13 and 4/30/13.
5. ODG Integrated Treatment/Disability Duration Guidelines: Low Back -Lumbar & Thoracic (Acute and Chronic) dated 4/15/13.

6. ODG Integrated Treatment/Disability Duration Guidelines: Pain (Chronic) dated 3/21/13.
7. TDI Assigned Designated Doctor's Evaluation and Report dated 2/27/13.
8. Benefit Dispute Agreement dated 1/3/13.
9. Clinic notes dated 1/4/12 and 2/22/12.
10. Clinic notes dated 3/5/12, 1/21/13 and 3/18/13.
11. Psychological Re-evaluation dated 4/10/12 and 3/25/13.
12. MRI Left Shoulder dated 1/30/12.
13. Post-Myelogram CT Lumbar Spine dated 1/30/12.
14. Lumbar Myelogram dated 1/30/12.
15. Radiograph Lumbar Spine dated 1/4/12.
16. CT Scan of Chest, Abdomen and Pelvis dated 11/7/11.
17. ER records dated 11/7/11.
18. Clinic notes dated 3/29/12.
19. Clinic notes dated 4/10/12, 5/14/12 and 6/11/12
20. Clinic notes from dated 11/28/11, 4/17/12, 5/2/12 and 7/16/12.
21. Texas Department of Insurance: Report of Medical Evaluation dated 9/6/12.
22. Texas Department of Insurance: Designated Doctor Examination dated 8/27/12.

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male with a history of lumbar fusion L5-S1 in 2002. The records indicated that the patient did well following the 2002 surgery until he fell off a forklift in. In the patient was involved in a rollover motor vehicle accident. The patient's diagnoses included chronic lumbar pain secondary to trauma, lumbosacral pain and neuropathy, post-laminectomy syndrome, and multilevel degenerative disc disease. A lumbar x-ray performed in January 2012 showed hardware being placed at 5-1 level and flexion/extension view showed prior fusion L5-S1 and is a 2-3 mm anterolisthesis of L4 on L5 which completely reduced on the extension view. A lumbar CT/myelogram dated 01/30/12 showed a posterior lumbar fusion L5-S1 with posterior hardware and near complete interbody bony fusion across L5-S1, moderate left bony foraminal stenosis at this level and severe degenerative facet hypertrophy L4-5 with some distortion of the thecal sac and crowding of nerve roots at this level without high grade central spinal stenosis along with severe left and mild right bony foraminal narrowing noted at this level. A physician record dated 03/18/13 revealed back pain and the patient requested an increase amount of narcotic pain medication. The examination revealed painful and restricted lumbar range of motion, painful flexion and extension, normal straight leg raise bilaterally, and normal reflexes. A spinal cord stimulator (SCS) has been recommended.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA's initial denial stated that that there was a lack of documentation of lesser levels of care such as injections and medications had been exhausted prior to SCS. On 4/17/13, the URA reported that the request was again non-certified. According to the URA, ODG criteria were not met as there was no evidence of radiculopathy or lower extremity pain.

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

In this patient's case, the Official Disability Guidelines (ODG) do not support the requested outpatient 2 Lead Spinal Cord Stimulator Trial (CPT Codes 63650, 95971, 72275.26 and 77003.26). Official Disability Guidelines states the indications for spinal cord stimulator are "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 spinal cord stimulator trial is not medically necessary or appropriate for this patient. Although there is evidence of a lumbar surgery in 2002 and a diagnosis of post-laminectomy syndrome, there is no evidence of Complex Regional Pain Syndrome and there is no evidence of radiculopathy or lower extremity pain. Additionally, there is lack of documentation of injections and medications provided. All told, a spinal cord stimulator trial is not indicated or appropriate as the ODG criteria were not met.

In conclusion, I have determined the requested outpatient 2 Lead Spinal Cord Stimulator (SCS) Trial (CPT Codes 63650, 95971, 72275.26 and 77003.26) is not medically necessary for treatment of the patient's medical condition.

**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 JUDGMENT, 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)