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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/3/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: spinal cord stimulator trial

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified Anesthesiologist and Pain Medicine

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. It is this reviewer's opinion that medical necessity has been established for the requested spinal cord stimulator trial

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes dated 01/04/13 – 05/09/13
Electrodiagnostic studies dated 01/24/13
Radiographs of the sacrum and coccyx dated 03/14/13
Behavioral health assessment dated 04/22/13
Clinical report dated 08/01/12
MRI of the lumbar spine dated 05/25/12
Prior reviews dated 04/29/13 – 06/10/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who initially sustained an injury on xx/xx/xx. The patient has had multiple low back surgeries to include an anterior fusion at L4-5 and L5-S1. Per the 01/04/13 clinical report, the patient has had ongoing complaints of pain radiating to the tailbone. It was unclear whether the patient had any lower extremity symptoms at this visit. The patient was noted to be on Neurontin at 1200mg a day. Physical examination demonstrated lumbar paraspinal tenderness with mild weakness in the right lower extremity on dorsa flexion. Other medications were noted to include Hydrocodone and Cymbalta. Electrodiagnostic studies completed on 01/24/13 demonstrated evidence of chronic L5 radiculopathy for the right lower extremity. Radiographs of the sacrum and coccyx from 03/14/13 indicated that the posterolateral graft at L5-S1 was not solid; however, the intervertebral graft did appear to be incorporated. The patient did undergo a behavioral health assessment on 04/22/13. Per the report, the patient reported fair to moderate relief of symptoms with the use of narcotics, Neurontin, and muscle relaxers. The patient did undergo prior epidural steroid injections, the use of physical therapy, and aquatic therapy. The patient reported severe low back pain radiating to the right lower extremity. The patient denied any thoughts about suicide and denied any current psychotropic medications. The patient's MMPI2 profile demonstrated validity scales within the normal range. No evidence of severe

depression or anxiety was present. The patient was felt to have no contraindications for a spinal cord stimulator trial. Follow up on 05/09/13 indicated the patient continued to have sleep difficulties despite the use of multiple narcotics including Methadone and Norco. The patient did have an increase in Neurontin to 1800mg a day with limited improvement. Physical examination was limited with no significant findings noted. The patient was then increased to Neurontin at 2400mg per day and Methadone was recommended to be titrated.

The requested spinal cord stimulator trial was non-certified by utilization review on 05/17/13 as the submitted request was not clearly for a spinal cord stimulator trial.

The request was again denied by utilization review on 06/10/13 as there was no detailed psychological evaluation stating the patient would be a good candidate for the procedure.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for chronic and refractory post-laminectomy syndrome that has not improved with multiple medications or injections. The patient has not significantly improved with titration of neuromodulating medications for her lower extremity pain. There is evidence of a chronic right L5 radiculopathy on the provided EMG study from January 2013. The patient's psychological evaluation from April of 2013 was valid and demonstrated no contraindications to a spinal cord stimulator trial. As there is no indication that the patient is considering any further surgical procedures, the request would be current evidence based guideline criteria and recommendations for a spinal cord stimulator trial for failed back surgery syndrome. As such, it is this reviewer's opinion that medical necessity has been established for the requested spinal cord stimulator trial and the prior denials are overturned.

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)