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**Notice of Independent Review Decision**

**DATE OF REVIEW:** December 22, 2014

**IRO CASE #:**

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

Dual spinal cord stimulator under fluoroscopy with intravenous sedation (CPT codes 63650, 63650-51, and 95972).

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

M.D., Board Certified in Physical Medicine and Rehabilitation with Sub-specialty Certification in 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)

I have determined that the requested dual spinal cord stimulator under fluoroscopy with intravenous sedation (CPT codes 63650, 63650-51, and 95972) is not medically necessary for the treatment of the patient's medical condition.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reportedly injured his right lower extremity on xx/xx/xx. He sustained a severe open traumatic tibia/fibula comminuted fracture of the right lower extremity with subsequent neural repair. An electrodiagnostic study reportedly indicated severe right sided peroneal motor neuropathy. Previous conservative treatment is noted to include lumbar sympathetic blocks, physical therapy, and medication management. The patient presented on 10/22/14 and was noted to have an antalgic, limping gait. It is noted that the patient has

responded favorably to treatment in the past, including the combination of sympathetic blockade with medication management. On 10/22/14, the patient was switched to a new prescription of Ultram 50mg, three times per day. A request has been submitted for dual spinal cord stimulator under fluoroscopy with intravenous sedation (CPT codes 63650, 63650-51, and 95972).

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial stated that although there is limited evidence in favor of spinal cord stimulators for failed back surgery syndrome and complex regional pain syndrome type I, more trials are needed to confirm whether spinal cord stimulators are an effective treatment for certain types of chronic pain. On appeal, the URA noted that there is no indication that the patient had a recent psychological evaluation to determine that he is currently a good candidate for this procedure.

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

The Official Disability Guidelines (ODG) state spinal cord stimulators are recommended only for selected patients with complex regional pain syndrome type I. They are also used in cases of failed back surgery syndrome. There should be evidence of a limited response to non-interventional care and documentation of psychological clearance. Permanent placement requires evidence of 50% pain relief and medication reduction or functional improvement following the temporary trial. Per the submitted documentation, the patient has been previously treated with lumbar sympathetic blocks, physical therapy, and medication management. However, it was noted on 10/22/14 that the patient has responded favorably to treatments in the past, including a combination of sympathetic blockade with medication management. Therefore, there is inadequate documentation of a limited response to non-interventional care. There also remains a lack of documentation of psychological clearance indicating realistic expectations and clearance for the procedure. All told, the requested dual spinal cord stimulator under fluoroscopy with intravenous sedation (CPT codes 63650, 63650-51, and 95972) is not medically necessary in this patient's case.

Therefore, I have determined the requested dual spinal cord stimulator under fluoroscopy with intravenous sedation (CPT codes 63650, 63650-51, and 95972) is not medically necessary for treatment of the patient's medical condition.

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**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)