

Notice of Independent Review Decision

Case Number:

Date of Notice: 09/16/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Anesthesiology

Description of the service or services in dispute:

Neuro stimulator implant

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)

Patient Clinical History (Summary)

Patient is an individual. On 01/20/15, the patient was seen. It was noted the patient had a diagnosis and complaints of hip pain and had previously undergone lumbar facet rhizotomy L2-3 and L3-4 on the left side on 07/15/14 and the patient reported 70% improvement that continued. Pain prior to procedure was 9/10 and pain post-procedure was 3/10. The patient reported having knee surgery on left side and she stated her pain had not gone away but had gotten worse. It was noted her spinal cord stimulator was working but where her back was burning the stimuli made that worse. A lumbar facet rhizotomy was recommended. The patient reported 70% improvement that continued from a previous lumbar facet rhizotomy performed on 02/03/15. On 06/19/15, the patient returned to clinic. Pain was rated at 6/10 going up to 9/10 worse in that morning. It was noted however, her activities of daily living had improved. She reported low back pain and left leg pain and it was noted she had thought about a revision of her stimulator but wanted try a pain pump. A spinal cord stimulator revision from T8 bilaterally was recommended. It was noted x-rays showed the leads were misplaced and the patient was not getting coverage from her current spinal cord stimulator.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 07/10/15, a peer review report for the requested neurostimulator implant was submitted noting the request was not medically necessary. It was noted this was not a new request for a stimulator and the patient already had a stimulator and this was not a request for a revision and it was unclear why the patient needed a revision. It was noted this was not discussed in the clinical notes provided for review and the request was non-certified. On 08/04/15, a peer review report for the requested neurostimulator was submitted noting the request was not medically necessary. It was noted the information provided did not establish the medical necessity of the requested procedure, as the patient had a previous spinal cord stimulator placement and there was lack of documentation as to functional improvement or decrease in medication use with that device. There was no clear identification of nerve root or dermatomal pattern of involvement for the anticipated coverage, and the request did not meet criteria.

The records submitted for this review indicate that x-rays showed the leads are misplaced, and the records did not document that the patient has had significant improvement in pain from the use of her spinal cord stimulator in the past. Additionally, when last seen, the patient had opted for a pain pump versus a spinal cord stimulator revision. As such, it is the opinion of this reviewer that the request for neurostimulator implant is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- 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 and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)