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Notice of Independent Review Decision

March 16, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Spinal cord stimulator for trial – Phase I

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female who was injured on xx/xx/xx, when she was picking up a bag and experienced burning and hurting in the lower back.

2013: On May 10, 2013, the patient was seen in an initial diagnostic screening, who reviewed additional records: *On April 19, 2007, the patient was diagnosed with lumbar herniated nucleus pulposus (HNP) at L4-L5. Computerized tomography (CT) scan dated February 16, 2009, showed T11-T12 and T12-L1 desiccation with rim lesions. The L2-L3 had desiccation with rim lesions. The L2-L3 had desiccation with rim lesions and thickening of the ligaments. The L3-L4 had mild posterior central herniation and ligamentum flavum hypertrophy. There was a broad based disc herniation at L4-L5. There was thickening of the ligamentum flavum and mild facet hypertrophy. At L5-S1, there was disc space narrowing at the broad based, central and paracentral herniation with rim lesions. There was noted a previous L5 laminectomy on the right. On January 15, 2010, the patient was seen and was prescribed a transcutaneous electrical nerve stimulation (TENS) unit. A functional capacity evaluation (FCE) dated September*

8, 2011, showed that the patient's elevated pain level interfered with the ability to focus and concentrate and even a sedentary job would be difficult for her. EMG of the lower extremities dated July 8, 2009, showed old chronic non-localized left L5 nerve root injury and right S1 nerve root injury, but no evidence of any current/ongoing nerve injury. MRI of the lumbar spine dated December 30, 2011, showed status post L5-S1 laminectomy and posterior fusion with pedicle screw instrumentation and clumping of the lumbosacral nerve roots in the thecal sac below L4 consistent with arachnoiditis. X-rays of the lumbar spine dated April 15, 2013, demonstrated instrumentation in place and mineralization appeared to be adequate. diagnosed the patient with depressive disorder non-specified, related to injury medical condition with anxiety features; adjustment disorder with mixed anxiety and depressed mood; pain disorder associated with work related injury medical condition and psychological factors; lumbar spinous stenosis and lumbar radiculitis. The patient was recommended participation in individual therapy consisting of cognitive behavioral modalities.

On July 22, 2013, noted that the patient continued left leg burning and numbness. The patient reported that previously she was getting up out of her chair and her right leg was not responsive causing her to fall forward and to the side. She reported poking sensation in the lumbosacral area. Her ongoing medications included hydrocodone-APAP, gabapentin, Cymbalta, indomethacin, tizanidine and zolpidem. On examination, the right hip flexors were weak and lumbar flexion increased and restricted range of motion (ROM) with pain. Lumbar x-rays obtained showed transpedicular flexion in place at L5-S1, marker in place at the L5-S1 spinal level and a 5 non-rib bearing lumbar vertebra. There was asymmetry of the pubic symphysis articulation. assessed status post decompression L5-S1 with discectomy, foraminotomy and hemilaminectomy at right L5-S1 (July 16, 2008); segmental spondylosis at L4-L5 and L5-S1; clinical radiculopathy; exogenous obesity; conjoined nerve root at right L5-S1; Baker's cyst posterior to the right lateral knee; internal derangement of the right knee with probable tear of the right lateral meniscus posteriorly; pseudoarthrosis on the right at L4-L5 per CT and myofascial pain syndrome; broad-based HNP at L4-L5. advised the patient to complete her psychotherapy and obtained spiral CT of the lumbar spine.

On August 14, 2013, CT of the lumbar spine revealed solid anterior and posterior fusion at L5-S1 with mild bilateral foraminal and right lateral recess stenosis due to osteophyte with abutment of the right S1 nerve root, mild-to-moderate multi-factorial central spinal stenosis at L3-L4 with mild compression at both L3 nerve roots and moderate central spinal stenosis at L1-L2 with ossification of the ligamentum flavum and posterior disc margin.

On December 11, 2013, the patient was seen for low back and right leg pain rated at 8/10. The pain in her low back radiated down to her right leg to her foot, with feeling of needles poking at her. The patient had exhausted all conceivable forms of physical therapy (PT) including chronic pain rehabilitation program, medications, surgery, injections, lifestyle adjustment and continued to have significant debilitating pain on a constant basis. MRIs showed slight listhesis at

L4/L5 with bilateral foraminal stenosis, worse on the right at L5 and S1. The patient also had clumping of the lumbar nerve roots, with evidence of arachnoiditis. She had been cared for, who had retired, but they were planning a trial of spinal cord stimulation. The patient had had psychological evaluation, which specifically stated that she had no contraindications to invasive medical care. Her cognitive status was definitely adequate to care for a spinal cord stimulator. She had no bleeding disorders. Lumbar Spine and sacrum examination showed decreased range of motion (ROM), moderate spasm and pain with palpation throughout the lumbar spine. Straight leg raise (SLR) was positive on the right side at 30 degrees. There was decreased sensation to light touch and pin prick in the L5 and S1. Motor strength was diminished 3/5 plantar and dorsiflexion, and weakness with toe pushups and heel walking. The diagnoses included chronic pain syndrome, radiculopathy/radiculitis, postlaminectomy lumbar region, back pain/lumbago, encounter for long term use of other medications and encounter for therapeutic drug monitoring. A random urine drug screen (UDS), was obtained as the patient was on controlled substances (opioid/benzodiazepine). Medications prescribed were Cymbalta, 20 mg, Flector 1.3% Patch, hydrocodone/APAP and Tizanidine HCL. An authorization for SCS was recommended.

On December 11, 2013, per history information, the patient was unable to work due to pain and was depressed. Her medications included gabapentin, hydrocodone, Cymbalta, tizanidine, bupropion, Singulair, Nexium and omega 3.

2014: In a letter dated February 26, 2014, wrote regarding the appeal for SCS trial. He stated the patient had had four separate lumbar surgeries including multi level fusion. She had continued significant low back pain radiating to lower extremity and had been treated for this. The patient was evaluated by a psychologist in preparation for SCS and there was no psychological problem ever noted on the initial evaluation. The patient had full capacity both mentally and had ability to operate a small device. A second psychological evaluation was planned as it was stated that the previous psychological evaluation had not been updated. However, this was denied since the insurance carrier stated that the patient would be denied a SCS trial at any rate and therefore a repeat evaluation was unnecessary. suggested reconsideration before the patient took the case to the insurance commissioner and DWC Board of Appeal.

From February 27, 2014, through August 27, 2014, the patient was seen on four occasions for medication refills. prescribed Ketamine cream and recommended getting another evaluation for his spinal cord stimulator (SCS) trial.

On August 27, 2014, urine drug screen (UDS) was positive for opiates.

On September 24, 2014, discussed the treatment opinions and gave handouts on chronic pain management. The patient was prescribed Ketamine 10%, Bupivacaine 1%, cyclobenzaprine 2%, ketoprofen 10% and gabapentin 6% compounded cream to apply three times a day to the affected area. Norco was refilled.

On November 18, 2014, UDS was again positive for opiates.

On November 19, 2014, recommended checking out the status on SCS and continued with ongoing medication management.

On November 19, 2014, UDS was positive for hydrocodone, nor hydrocodone and hydromorphone.

2015: On January 28, 2015, suggested implantable neurostimulation electrodes. He continued the patient on the prescribed medications to include Cymbalta, hydrocodone-APAP, tizanidine-HCL, Pentravan cream, Buspirone, cyclobenzaprine and gabapentin.

On January 28, 2015, UDS was positive for opiates 300.

Per utilization review dated February 2, 2015, the request for SCS trial was denied with the following rationale: "*The records indicate this patient has received a psychological evaluation and in fact 2, with the 1st one in 2010 for preoperative evaluation for a lumbar spine surgery. That pre-op evaluation was stated to be good. In 2013, she had a psychological evaluation prior to a spinal cord stimulator trial and at that time it was recommended that she undergo individual cognitive behavioral psychotherapy. The submitted records for this review did not indicate whether she has completed psychological therapy if she has completed therapy, the overall effects of that therapy have not been documented by the records. While the provider has discussed urine drug screens, no urine drug screens were provided for this review most recently to indicate this patient is not aberrant with her medications. Guidelines indicate this procedure may be considered reasonable for those patients such as this, with post-laminectomy syndrome, who have failed all lesser measures, who have a psychosocial evaluation that has cleared the patient for the procedure, and there is an indication that the patient has no evidence of diversion. At this time, lacking documentation of a complete psychosocial evaluation clearing this patient for the requested procedure, and lack of documentation of urine drug screens to indicate this patient is not divergent or aberrant, this request does not meet current guideline criteria and the recommendation is for non-certification. The patient has severe failed back surgery syndrome. She is failed a whole host of conservative therapies. Unfortunately, a prior psych evaluation was deemed inappropriate because it was specifically for lumbar surgery and he is unable to get another psychological evaluation approved."*

Per reconsideration review dated February 10, 2015, the appeal for denial of the SCS trial was upheld with the following rationale: *"There has been no psych evaluation to clear the patient for the SCS trial. The last psych evaluation was two years ago before her last surgery. She may be a candidate for the SCS from a pain perspective, but a psychological evaluation needs to be done first to verify this."*

On March 5, 2015, refilled hydrocodone-APAP and provided handouts for chest pain. He recommended follow-up in two months.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Patient meets criteria for trial of spinal cord stimulation for intractable pain following surgery. Patient has passed a valid psychological screen and has no contra indications.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**