

P-IRO Inc.

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DATE OF REVIEW: JUNE 11, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Trial of a spinal cord stimulator-Upper Extremities

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

Board Certified
Pain Management

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Cervical spine MRI, 08/08/04
Left shoulder MRI, 10/03/05
Office note, Dr., 11/07/05
Operative note, 12/02/05
Notes, 12/13/05, 02/17/07, 03/03/06, 03/17/06, 03/31/06, 04/17/06, 05/30/06, 01/02/07 and 04/16/07
Notice of denial of trial of spinal cord stimulator, 03/22/07
Notice of denial of reconsideration for spinal cord stimulator trial, 03/30/07
clinic notes, 05/17/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is currently a female employed as a fabrication specialist. She sustained injuries in a fall on xx/xx/xx with a spiral fracture of the humerus and a brachial plexus injury. Initial treatment included therapy, medications and injections but she continued with left upper pain. An office note written on 11/07/05 by Dr. documented paresthesia in the left C7 distribution, a slightly bluish discoloration in the left upper extremity and hyperesthesia in a stocking glove pattern in the left upper extremity. Reflexes were intact. EMG reportedly showed brachioplexopathy and left chronic and severe pain and the diagnosis was regional sympathetic dystrophy and cervical radiculopathy. The

claimant underwent a series of five left stellate ganglion blocks in February and March of 2006 with some noted improvement.

The claimant presented with increased pain under the left arm and into the left breast on 01/02/07. Exam findings were essentially unchanged and included tingling in the left palm. The claimant continued on narcotic pain management but was hesitant to take the medications due to unwanted side effects of poor concentration and excessive drowsiness. A trial of a spinal cord stimulator was recommended and non-certified on two separate occasions.

A recent office note on 04/1607 documented that the claimant's medications included Nortriptyline and Hydrocodone. Dr, once again submitted the request for spinal cord stimulator trial.

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

The claimant is a female with a history of a fall and spiral fracture to her humerus. She also presents with a classic brachial plexus stretch injury pathology. Subsequent MRIs have shown remarkably little pathology. However, EMG reports show a brachial plexopathy. The claimant has also demonstrated improvement with left stellate ganglion blocks from February through March of 2006. The claimant's presentation on physical examination also supports a diagnosis of brachial plexus stretch injury with the development and expansion of reflex sympathetic dystrophy.

In this case, a spinal cord stimulator trial would be both diagnostic and therapeutic. This, in the Reviewers experience, gets best results when combined with physical therapy. Long term, this has the best potential hope of diminishing further disability, and allowing this patient to either return to work or continue at present employment. Therefore, based upon review of the medical records provided, a trial of a spinal cord stimulator would be recommended as medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2007 updates (chronic pain, stress-related, mental health disorders)

Spinal cord stimulators (SCS) should be offered only after careful counseling and patient identification and should be used in conjunction with comprehensive multidisciplinary medical management. CRPS patients implanted with SCS reported pain relief of at least 50% over a median follow-up period of 33 months. SCS use has been associated with pain reduction in studies of patients with CRPS. Moreover, there is evidence to demonstrate that SCS is a cost-effective treatment for CRPS-I over the long term. (Taylor, 2006) (Stanton-Hicks, 2006) (Mailis-Gagnon-Cochrane, 2004) (Kemler, 2000) Permanent pain relief in CRPS-I can be attained under long-term SCS therapy combined with physical therapy. (Harke, 2005) See Spinal cord stimulators (SCS). Functional brain imaging may represent an excellent opportunity to provide an objective measurement of pain in CRPS and provide a means to monitor treatment efficacy. (Prager, 2007)

Recommended pre intrathecal drug delivery systems (IDDS) and spinal cord stimulator (SCS) trial. The following is a list of patients who are especially recommended for psychological evaluation pre- trial (Doleys): (a) Those who present with constant pain and report high overall levels of distress; (b) Patients' who have a history of failure of conservative therapy; (c) Patient's who have a history of failed surgery; (d) Patients who

have significant psychological risk factors such as substance abuse, serious mood disorders, or serious personality disorders.

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 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)