



## REVIEWER'S REPORT

**DATE OF REVIEW:** 04/06/10

**IRO CASE #:**

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

Explantation of spinal cord stimulator electrodes and generator with fluoroscopy

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. TDI Referral
2. URA denials, 3/12 to 31/19/2010
3. MD, office notes 6/4/09 to 2/25/2010
4. MD, surgical note, spinal cord stimulator implant, 4/2/2009.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This individual has chronic CRPS of the upper extremities. A spinal cord stimulator was implanted, which provides greater than 50% pain relief. There are significant psychological factors contributing to her pain complaints, and psychological treatment has been requested. The patient is complaining of tenderness over the generator site, but there is no induration, redness, or any signs of infection.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

The ODG Guidelines do not address explantation of spinal cord stimulator. Clinical judgment is the basis of the review. This individual has overwhelming psychological issues that should be addressed prior to explanting the stimulator. The stimulator is providing greater than 50% pain relief, and I fear if it were explanted, her CRPS upper extremity pain would worsen. It is not indicated to remove the stimulator at this time. At this time it is unclear whether the patient has a true understanding that her pain might worsen if the stimulator were explanted.

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

*(Check any of the following that were used in the course of your review.)*

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)