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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: September 13, 2011

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Electric Stimulation Once a Month up to 12/2011 (97014)

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines (ODG)

Peer Review Letter: 07/21/11

Peer review Letter 08/02/11

Office Notes PCP Dr. MD: 12/16/09, 07/01/10, 08/02/10

Referral Form to Dr.: 07/14/10

Office Notes Dr., DC: 11/01/10, 11/12/10, 11/30/10, 12/10/10, 12/16/10, 12/28/10, 01/21/10, 02/17/11, 03/03/11, 03/25/11, 04/21/11, 05/11/11 06/01/11, 06/09/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained work related injuries to her bilateral upper extremities. She was employed as a and was injured as a result of repetitive motion reported on xx/xx/xx. The current diagnosis is chronic neck and upper back pain. Review of records revealed that the claimant has a very long and involved medical history documenting many years of conservative and surgical care for bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, bilateral thoracic outlet syndrome and multiple crush syndrome along with regional dystrophy syndrome. The claimant's recent care has been provided by her PCP, Dr. who referred her to Dr. DC on 07/14/10 for care, evaluation and treatment of persistent pain, numbness and tingling in the bilateral upper extremities and hands. Submitted records from Dr. spanned from 11/01/10 to 06/09/11. The request for electrical stimulation once per month up to 12/2011 was denied once on 07/21/11 and again on 08/02/11. There was not any new clinical information submitted for this review.

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

The claimant has chronic neck and upper back pain. She is status post multiple tunnel symptom surgeries, Multiple Crush Syndrome, Bilateral Thoracic Outlet syndrome status post

surgery, Tendinitis, Cubital tunnel syndrome, status post Ulnar transposition both elbows and RSD, reportedly all associated with repetitive motion in xx. The claimant complains of neck and back pain. It is not clear if the claimant has utilized anti-inflammatory medications or pain medications. It is unclear if the claimant has done a home exercise program. It is unclear if the claimant has recently had physical therapy, stretching, range of motion, or tried E Stim or a TENS Unit as a diagnostic modality. Electrical muscle stimulation (EMS) is not recommended in ODG for neck pain. The reviewer finds there is not a medical necessity for Electric Stimulation Once a Month up to 12/2011 (97014) at this time.

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates

Neck and Upper Back Chapter -- Electrical muscle stimulation (EMS)

Not recommended. The current evidence on EMS is either lacking, limited, or conflicting.

There is limited evidence of no benefit from electric muscle stimulation compared to a sham control for pain in chronic mechanical neck disorders (MND). Most characteristics of EMS are comparable to TENS. The critical difference is in the intensity, which leads to additional muscle contractions. Primary pain relief via gate control may be obtained by EMS, TENS, or other forms of ENS. The theory is that rhythmic muscle stimulation by modulated DC or AC probably increases joint range of motion, reeducates muscles, retards muscle atrophy, and increases muscle strength. Circulation can be increased and muscle hypertension decreased, which may lead to secondary pain relief. (Kroeling-Cochrane, 2005) Since the quality of evidence is low or very low, we cannot make any definite statements on the efficacy and clinical usefulness of electrotherapy modalities for neck pain. There is very low quality evidence that electric muscle stimulation (EMS) is not more effective than placebo. EMS did not reduce pain or disability. (Kroeling, 2009) See also Electromagnetic therapy (PEMT); Galvanic current; Iontophoresis; Magnets; Repetitive magnetic stimulation (rMS); & Transcutaneous electrical neurostimulation (TENS).

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

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE

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)**