IRO REVIEWER REPORT TEMPLATE – WCN

DATE OF REVIEW: 2/19/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

RS4i Stimulator and supplies.

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

Board Certified in Orthopedic Surgery

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.

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Dates of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Uphold/ Overturned*
722.10	99070	N/A	prospective	N/A	N/A	N/A			Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 2/6/07
2. Determination Notices – 12/4/06, 12/13/06
3. Request for Authorization – 11/28/06, 12/4/06
4. Medical Prescription & Patient Usage Report – 8./25/06-12/30/06
5. Letter of Medical Necessity – 11/4/06
6. Care Records and Correspondence – 10/6/06

7. MD Letter – 10/19/06

PATIENT CLINICAL HISTORY :

This case concerns an adult male who sustained a work related injury on. Records provide no details about the circumstances of the injury. Diagnoses have included lumbar disc displacement, bilateral facet arthrosis, and disc protrusion. Evaluation and treatment for this injury has included anterior-posterior fusion L5-S1, medications, physical therapy, massage, floor exercises, x-rays, and electrical stimulation.

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

The physician reviewer indicated that this patient has had chronic back pain after fusion for degenerative lumbar pathology. There is no class I data to support the use of the RS4i stimulator for this condition. The literature does not support its use for back pain and it is not within the accepted standard of care for treatment of this patient's condition. It is considered experimental treatment at this time and not medically necessary for this patient's condition.

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)**

Van Tulder MW, et al. Outcome of non-invasive treatment modalities on back pain: an evidence-based review. Eur Spine J. 2006 Jan; 15 Suppl 1:S64-81.