IRO America Inc.

An Independent Review Organization
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DATE OF REVIEW: *5/2/07*

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Out patient surgical services--Disputed is a peripheral nerve stimulator trial

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
MD board certified in Physical Medicine and Rehabilitation and specialized in 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
Case Assignment from TDI, Records from including from the dates August 2005 through December 2005 and May 2006 until January 2007 including: treating physician notes, adverse determination letter, appeal/reconsideration letter, patient/injured employee IRO request form, Company request for IRO form, and signed confirmation page, and imaging report, and letter from FOL and supporting documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant sustained a left shoulder injury while attempting to catch a fainting patient, and previously at work while lifting a stretcher. She had conservative

therapy after the first injury, but ultimately required surgery and was able to return to work until she sustained the second injury which produced the same pain as before. Conservative therapy has helped, but inadequately for the patient to resume an appropriately active lifestyle.

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

After a careful review of all medical records the Reviewer's medical assessment is that this claimant has had an appropriate course of conservative and surgical therapies for her chief complaint, with suboptimal functional results. A peripheral nerve stimulator is a widely used and predominantly successful procedure that would be medically necessary with this patient. It has the potential to allow her to return to an active lifestyle that she enjoyed before her work-related injuries and is therefore medically necessary.

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)