

SENT VIA EMAIL OR FAX ON
Dec/07/2010

IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/30/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Stim Replacement--Insertion or replacement of spinal neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form battery status, electrode select-ability, output modulation, cycling, impedance and patient compliance measurements): simple spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming; complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, first hour; Anesthesia for procedures in lumbar region, not otherwise specified; Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 10/5/10 and 10/26/10

Dr. 9/20/10 thru 10/19/10

PATIENT CLINICAL HISTORY SUMMARY

This is a man. The limited records stated he has postlaminectomy syndrome since an injury in xxxx. The 9/20 notes from Dr. reported the pain went to the left lower extremity. There is a hand written comment on 10/19 stating only the batter replacement was requested on the

SCS revision form. The 10/18/10 note states that the “battery is totally dead.” It described, “his pain is totally out of control.”

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

The 10/20 note was the only one of the two notes provided describing the device as helping this man. Once this was documented, the battery replacement can be justified as medically necessary.

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 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)