

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: April 6, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Office visit for possible adjustments of spinal cord stimulator and medications

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

3/3/11, 3/16/11

D.O. 3/10/06 to 1/11/11

Surgery Center 2/26/08 to 1/4/11

Up & Open MRI 4/28/05

Open MRI 4/26/04

Solutions 3/23/10

2/26/08

Official Disability Guidelines Treatment in Worker's Compensation

PATIENT CLINICAL HISTORY SUMMARY

This is a patient who, according to the medical records, had a spinal cord stimulator implantation with good results for fourteen months until the battery expired. The battery was changed and the stimulator reprogrammed, once again with good coverage. Based upon the records, it supposedly helped for the chronic pain situation and is providing excellent relief. Office visit for possible adjustments of spinal cord stimulator and medications were denied.

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

The prior reviewers denied this office visit because there was no clear rationale for adjusting the stimulator nor were there sufficient records provided regarding the patient's medications. The medical records made available for this review reflect a different situation. At this point in time, given the medical records reflecting its efficacy, this reviewer believes it is shortsighted to deny an office visit for adjustments and programming, given the benefits that are stated to

be received by the patient. The patient's medication regimen also requires monitoring. The request certainly meets the criteria of the Official Disability Guidelines and Treatment Guidelines. ODG recommends office visits as determined to be medically necessary and encourages them. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned. The reviewer finds there is a medical necessity at this time for Office visit for possible adjustments of spinal cord stimulator and medications.

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)