

DATE OF REVIEW: 06/25/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Purchase of RLSO (RS-2m)

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

Board Certified, DWC Approved Doctor List Level II, with more than nineteen years experience.

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. RS Medical prescription dated 05/29/07
2. Progress note from Dr. dated 04/08/07
3. Letter of Medical Necessity dated 05/30/07 by Dr.
4. Reports of physician advisers dated 04/17/07 and 05/02/07

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

No specific history regarding this claimant’s work injury of xx/xx/xx was provided from the requesting physician. According to the physician adviser reports, the claimant injured herself while unloading files at work. X-rays had apparently been taken, demonstrating no pathology. The claimant was seen by Dr. on 04/08/07 complaining of low back pain. At that time she was taking diclofenac, ketorolac, cyclobenzaprine, and Celebrex. Physical examination documented negative straight leg raising test bilaterally, normal toe-and-heel walking, nonspecific tenderness at the L5/S1 level, and mildly decreased lumbar range of motion in flexion to 75 degrees. No physical examination evidence of muscle spasm was documented. Dr. indicated that he would order a trial of an interferential unit and continue the claimant in physical therapy for three to four more sessions beyond the eight sessions that she had attended. On 05/29/07 a standard prescription form from RS Medical was filled out for indefinite use of an RS-2m machine to “relax muscle spasms” and “maintain or increase range of motion.” On 05/30/07 Dr. signed what appears to be the usual form letter requesting purchase of the RS-2m unit to “either supplement or replace physical therapy regimen for cost savings.” He indicated that the unit had been “very instrumental in the improvement of this patient’s condition as well as proper rehabilitation” and that it had “helped alleviate painful symptoms due to a diagnosis of sprain of the lumbar region and lumbosacral neuritis.” Two different physician advisers reviewed the request for purchase of this unit, on 04/17/07 and then on

05/02/07. Both recommended nonauthorization based on ODG Guidelines and national standards. The second physician adviser documented that he actually spoke with the requesting physician, Dr., documenting that Dr. "stated that he typically only requests rentals of these devices" and that he was "withdrawing the request."

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

There is no medical documentation of this claimant having a condition of chronic muscle spasms or significant decrease in lumbar range of motion for which purchase of this unit would be considered medically reasonable and necessary. Additionally, there is no documentation whatsoever that this unit has provided this claimant with any clinical benefit during the trial period. Finally, the requesting physician himself stated that he was withdrawing the request for this purchase when the case was discussed with the second physician reviewer. Therefore, based upon the lack of any documentation of clinical benefit, lack of any physical examination evidence of muscle spasms or significantly decreased lumbar range of motion, and the stated plan of the requesting physician with withdraw this request, there is no medical reason or necessity for purchase of the requested durable medical equipment. Furthermore, national clinical practice guidelines do not support the long-term use of this DME device for lumbosacral strain, nor are there any studies demonstrating clinical superiority or efficacy greater than doing active exercise to treat lumbosacral strain. The adverse determinations, therefore, are upheld.

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

(Check any of the following that were used in the course of your review.)

- X_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.
- X_Medical judgement, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- X_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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)