

**DATE OF REVIEW: MARCH 19, 2007**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Under dispute is the prospective and/or concurrent, retrospective medical necessity of RS-4I stimulator.

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

Board-certified Internal Medicine

**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**

Notification of Case Assignment, Medical Records from Requestor including a Usage Report 11/29/06, Diagnosis Report 10/16/06 and Request for Preauthorization on 12/15/06. Respondent denial information dated 1/12/07 and 1/4/07. URA records dated 3/1/07. Treating Doctor (s), including medical records from Drs. and from 10/06 to 3/07, form letters from the manufacturer, and carrier correspondence.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

No date or mechanism of injury is provided. The Patient underwent an unknown arthroscopic surgery in November 2006. There is reference to a post-operative MRI that showed a lateral meniscal tear and edema. Some worksheets document the use of the stimulator.

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

The Patient sustained a knee injury at some time in the past that required surgical repair. MRI shows a tear in the lateral meniscus. Interferential stimulation is not indicated in the treatment of recurrent/persistent meniscal tears. Neither is it indicated in the post-operative rehabilitation period. A course of physical therapy is indicated in the post-op period to rebuild strength and function.

**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)