5068 West Plano Parkway Suite 122
Plano, Texas 75093
Phone: (972) 931-5100
Fax: (888) UMD-82TX (888-863-8289)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Tens Unit- claimant has had for one month and the physician wants for him to keep it (purchase)

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

This case was reviewed by a Texas licensed MD, specializing in Neurological Surgery,Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery
TX DWC ADL

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Tens Unit- claimant has had for one month and the physician wants for him to keep it (purchase)		-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	Office Visit	Orthopaedic Surgeons	4	09/26/2007	11/14/2007

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is listed as. The patient reportedly fell off a machine and landed flat against his back on dirt causing him to hyperextend his back. Physical examination on 09/26/07 reported palpable tenderness throughout the paracervical, parathoracic and paralumbar musculature. There is pain with forward flexion of the cervical and lumbar regions. Range of motion is painful in all extremes within the

lumbar and cervical regions. Muscle strength is 5/5. Sensation is intact in all dermatomes. Straight leg raising of the lower extremities causes pain within the lower back. MRI of the cervical and lumbar spine was obtained. No radiology reports were submitted for review, but the imaging studies reportedly showed minimal disc derangement of both cervical and lumbar spine. Treatment to date includes physical therapy. The patient was seen in follow up on 11/14/07 and is noted to have occasional pain and discomfort within the low back with activity. The patient is noted to have used a TENS unit for one month with relief noted. The reason for referral is medical necessity for purchase of TENS unit. This request was denied on 11/19/07 by Dr.. Specific reasons other than clinical presentation and evidenced based guidelines were not given for the denial.

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

Based on the clinical information provided, the request for purchase of TENS unit is not medically necessary. The patient is noted to have sustained an injury. Imaging studies are noted to reveal minimal pathology in the cervical and lumbar spine. The patient has participated in physical therapy and has improved. There is no current physical examination submitted for review. The most recent progress note is dated 11/14/07. Per ODG guidelines, TENS is not generally recommended for chronic low back pain as there is strong evidence that TENS is no more effective than placebo or sham.

ODG TENS (transcutaneous electrical nerve stimulation)
Not recommended as as an isolated intervention, but a one-month home-based TENS trial may be considered as a noninvasive conservative option for chronic back pain, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration, including reductions in medication use.
Acute: Not recommended based on published literature and a consensus of current guidelines. No proven efficacy has been shown for the treatment of acute low back symptoms. (Herman, 1994) (Bigos, 1999) (van Tulder, 2006)
Chronic: Not generally recommended as there is strong evidence that TENS is not more effective than placebo or sham. (Airaksinen, 2006) There is minimal data on how efficacy is affected by type of application, site of application, treatment duration, and optimal frequency/intensity.

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

ODG: