



Notice of Independent Review Decision

RO REVIEWER REPORT

DATE OF REVIEW: 12/16/09

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for the purchase of a TENS unit with electrodes.

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

Texas licensed anesthesiologist

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.

The previously denied request for the purchase of a TENS unit with electrodes.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Notice of Assignment of Independent Review Organization dated 12/1/09.
2. Notice to. of Case Assignment dated 12/1/09.

3. E-Mail Message dated 12/1/09.
4. Fax Cover Sheet/Authorization Request Note/Comment/Message dated 12/1/09.
5. Fax Cover Sheet/Note/Comment/Message dated 12/1/09.
6. Request Form for a Review by an Independent Review Organization dated 11/27/09.
7. Notice (unspecified date).
8. Denial Information dated 11/27/09.
9. Literature/Article (unspecified date).
10. Physician Record/Addendum/Pre-Authorization Request dated 11/28/09, 10/29/09, 9/29/09, 9/18/09, 9/4/09, 9/3/09, 8/18/09, 8/4/09, 7/22/09, 7/6/09, 6/11/09, 6/7/09, 6/5/09, 5/26/09, 5/13/09, 5/12/09, 4/29/09, 4/24/09.
11. Patient Pain Drawing/Index dated 11/27/09, 10/29/09, 9/18/09, 9/4/09, 9/3/09, 8/18/09, 8/4/09, 7/6/09, 6/11/09, 6/5/09, 6/4/09, 5/26/09, 5/13/09, 5/12/09, 4/29/09.
12. Prescription Listing dated 11/27/09.
13. Determination Notification Letter dated 11/11/09, 9/21/09, 8/6/09, 8/5/09, 7/23/09, 7/14/09, 4/30/09.
14. Pre-Authorization Request dated 11/10/09, 7/6/09 (unspecified date).
15. Pre-Authorization/Treatment Plan for Workers' Compensation Physical Medicine Treatment dated 11/10/09, 9/17/09, 7/6/09.
16. Texas Workers' Compensation Work Status Report dated 11/5/09, 9/29/09, 9/18/09, 8/18/09, 8/6/09, 7/6/09, 5/26/09, 4/29/09.
17. Department of Workers' Compensation Form-69 dated 11/2/09.
18. Report of Medical Evaluation dated 10/28/09, 8/6/09.
19. Designated Doctor Exam Addendum/Report dated 10/29/09, 10/28/09, 8/6/09.
20. Cover Sheet/Follow-Up Evaluation Report dated 10/21/09, 9/23/09.
21. Cover Letter/Clarification Response Letter dated 10/20/09, 10/14/09.
22. Clarification Response Letter/Additional Medical dated 10/8/09.
23. Document Notes Cover Sheet dated 9/23/09, 9/19/09, 8/14/09.
24. Psychological Documentation Record dated 9/21/09.
25. Functional Capacity Evaluation Report/Summary Form dated 9/21/09.
26. Functional Capacity Evaluation Worksheet dated 9/21/09.
27. Modified Naughton Treadmill Test Worksheet dated 9/21/09.
28. History and Physical Report/Pre-Authorization Request dated 9/18/09, 4/24/09.
29. Medical Opinion Letter (unspecified date).
30. Fax Cover Sheet/Message/Pre-Authorization Request/Referral Form (unspecified date), 9/17/09, 8/18/09.
31. Initial Evaluation Report dated 9/9/09.
32. Trigger Point Injection Procedure Note dated 9/4/09, 6/5/09.

33. Physical Testing dated 9/3/09, 6/11/09, 5/26/09, 5/11/09.
34. Physical Performance Test/Exam Summary dated 9/3/09, 5/26/09, 5/11/09.
35. Patient/Employer/Worker's Compensation Information Form dated 8/25/09.
36. Cervical Spine MRI dated 8/7/09.
37. Primary Rehabilitation Progress Note/Home Exercises dated 8/3/09, 6/9/09, 6/3/09, 6/1/09, 5/29/09, 5/27/09, 5/25/09, 5/22/09, 5/18/09, 5/15/09, 5/13/09, 5/8/09, 5/6/09, 5/1/09.
38. Therapeutic Activities Record dated 8/3/09, 6/9/09, 6/3/09, 6/1/09, 5/29/09, 5/27/09, 5/25/09, 5/22/09, 5/20/09, 5/18/09, 5/15/09, 5/13/09, 5/8/09, 5/6/09, 5/1/09, (unspecified dated).
39. TENS Unit Rental Agreement dated 7/29/09.
40. Fax Cover Sheet/Note dated 7/22/09.
41. Designated Doctor Appointment Notification Letter dated 7/20/09.
42. Notice of Disputed Issue(s) and Refusal to Pay Benefits dated 6/16/09.
43. Cervical Spine X-Ray dated 5/13/09.
44. Initial History and Physical Report dated 4/29/09.
45. Workers' Compensation Insurance Verification dated 4/24/09.
46. Worker's Compensation History dated xx/xx/xx.
47. Employer's First Report of Injury or Illness dated xx/xx/xx.
48. Supplies – Dispensed in-House/Form (unspecified date).
49. Copy of Addressed Envelope (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Trying to keep a cart from tipping over.

Diagnosis: Shoulder pain/chronic strain.

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

This male sustained an industrial injury on xx/xx/xx. The initial mechanism of injury was trying to keep a cart from tipping over. The current diagnosis was shoulder pain/chronic strain. The patient was currently complaining of shoulder pain. He completed a course of physical therapy (PT), in May and June of 2009, without a significant resolution of his symptoms. An MRI of the shoulder showed chondromalacia and tendonitis. He received his TENS unit trial on 7/29/09. The orthopedic examination, on 9/9/09, indicated that the patient continued to be symptomatic. There was a notation of decreased range of motion (ROM) and positive impingement sign. The patient had a subacromial injection, on 9/23/09, which provided some relief for 2 weeks. There were monthly TENS evaluation

forms which indicated that the patient's pain was relieved at least 40%; however, this had not resulted in any functional improvement as the patient remained off of work. Per the ODG shoulder chapter, "TENS: Recommended post-stroke to improve passive humeral lateral rotation, but there is limited evidence to determine if the treatment improves pain. (Price, 2000) For other shoulder conditions, TENS units are not supported by high quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapy providers available for referral." Per the ODG pain chapter, "Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): - Documentation of pain of at least three months duration - There is evidence that other appropriate pain modalities have been tried (including medication) and failed - A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial." The patient had chronic pain in the shoulder, a diagnosis for which a TENS unit is not recommended. Furthermore, the trial of TENS therapy failed to improve the patient's functional status. Therefore, in accordance with the ODG, the previous recommendation for an adverse determination is upheld.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 7th Edition (web), 2009, Shoulder and pain chapters, TENS unit.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).