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DATE OF REVIEW:
Jun/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
EMPI 300 PV Electric Stim and Supplies - 3 Month Rental

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified in Physical Medicine and Rehabilitation

REVIEW OUTCOME:

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

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG Guidelines and Treatment Guidelines
Determination Letters, 4/24/09, 3/20/09
Physician's Statement of Medical Necessity/Prescription, 1/28/09
OT Re-evaluation, 2/23/09, 1/26/09
Letter from Patient, 4/9/09, 5/12/09
OT Referral, 1/26/09
Rehabilitation Specialists, 1/7/09
Dr MD, 4/23/09

PATIENT CLINICAL HISTORY SUMMARY
This woman was treated for pain due to tendinitis, myofascial pain, cubital tunnel and carpal tunnel syndrome. There was a request for a home TENS/ Estim unit. The records indicate this woman uses the unit for her myofascial pain, and not for tendinitis or the carpal tunnel syndrome. She has written that her pain has improved.

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

Records submitted for this review indicate this patient is not using the device in question for CTS. TENS units are not approved for CTS per the ODG. While the unit is approved for use after a month's trial for neuropathic pain, phantom pain, CRPS II and Spasticity, it is not approved for the treatment of myofascial pain. However, there is a role for the use of interferential current per the ODG. The ODG considers interferential current as "Possibly appropriate…if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical therapy…" The records indicate clearly that this unit is working for the claimant and is helping to alleviate her pain. The records

indicate that she has been able to work. There is evidence of increased functional improvement and less reported pain. These facts lead to its acceptance under the ODG clause as cited above. The reviewer finds that medical necessity exists for EMPI 300 PV Electric Stim and Supplies - 3 Month Rental.

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

[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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)