



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

09/15/2009

DATE OF REVIEW: 09/15/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 purchase of Interferential Unit and 1 purchase of Back Garment

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

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.

PATIENT CLINICAL HISTORY:



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The patient is status post injury on xx/xx/xx. The patient, since that time, still has low back pain that is nonradiating. Patient, on physical exam, has sensory changes on the right side greater than the left. Patient is status post laminectomy and has the diagnosis of post-laminectomy syndrome. According to the medical notes reviewed, the patient has had treatment with medication, facet injections, and epidural steroid injections. MRI shows an L5-S1 disc herniation, and patient has had a trial with a garment unit with good relief.

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

The purchase of the interferential unit and the purchase of a back garment are noncertified. The Official Disability Guidelines state it is not recommended. Refer to the Official Disability Guidelines' chapter on pain it talks about an RS1 garment stimulator. Interferential unit and the purchase of a back garment, it stays that these are not recommended as isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including returning to work, exercise, and medication, and limited evidence of improvement on those recommended treatments alone. The findings from these trials are either negative or insufficient for recommendation due to poor study design. The ODG state in addition, although proposed for treatment in general soft-tissue injuries enhancing wound to fascia, there is insufficient literature to support interferential current stimulation for treatment of these conditions.

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)



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- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**