

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2-LEAD TENS UNIT FOR PURCHASE

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Pre-Authorization Report: 04/30/10

Office Note, Dr. 09/22/09, 10/07/09, 10/23/09, 11/23/09, 12/23/09 and 02/22/10

Therapy Note: 09/22/09, 09/23/09, 09/25/09, 09/28/09, 09/30/09, 10/25/09, 11/24/09, 12/02/09, 12/07/09, 12/09/09, 12/11/09, 12/14/09, 01/25/10, 01/27/10, 02/01/10, 02/08/10, 02/10/10, 02/13/10, 02/17/10, 02/23/10, 02/24/10, 02/26/10, 03/08/10, 03/10/10, 03/15/10, 03/17/10, 03/19/10, 03/26/10

MRI Report: 10/02/09 and 10/16/09

Radiology Report: 10/02/09 x 2.

Physical Performance Evaluation: 10/07/09 and 03/25/10

Office Note, Dr.: 10/19/09, 12/21/09 and 02/03/10

Operative Report: 12/17/09

Office Note, Dr.: 04/19/10

Service Corporation, 4/30/10, 4/19/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a reported injury on xx/xx/xx when he was maneuvering a stretcher with a 200-pound patient on it and the stretcher gave way causing him to twist and fall. He reported left knee and left shoulder injuries. He initially treated with Dr., chiropractic neurologist, for rehabilitation of both the left shoulder and left knee. This review is primarily for the left knee. The claimant has a history of left knee anterior cruciate ligament and lateral collateral ligament reconstruction with partial lateral meniscectomy in 1972. Physical

examination of the left knee by Dr. on 03/22/09 demonstrated trouble walking, kneeling, squatting, negotiating stairs and with prolonged standing; tender medial joint line; motion from 1-111 degrees; painful lateral and medial stressing with stable anterior posterior stressing; and slow guarded ambulation. The claimant treated with chiropractic therapy modalities, Biofreeze and neoprene knee sleeve without significant improvement. Left knee MRI evaluation performed on 10/02/09 showed anterior cruciate ligament deficient knee with tri-compartment arthrosis; diffuse cartilage thinning with grade III chondromalacia; free edge fraying at the lateral meniscal remnant; and horizontal cleavage tear of the posterior horn of the medial meniscus.

Left knee radiographs also obtained on 10/02/09 noted previous collateral ligament injury with prior fracture deformity of the lateral tibial condyle; extensive chondrocalcinosis; and moderate effusion. The claimant continued to demonstrate limited left knee motion and decreased strength. The claimant underwent orthopedic evaluation for the left knee by Dr. on 10/19/09. The claimant reported medial knee pain with clicking associated with certain activities. Physical examination demonstrated mild medial collateral ligament laxity without joint line tenderness; painful medial McMurray's and rotation stress test; no tenderness along the lateral joint line; and negative drawer, pivot shift and Lachman. The claimant underwent right knee arthroscopy, arthrotomy and osteochondral grafting on 12/17/09. Intraoperative findings included normal medial meniscus; loose body underneath the medial meniscus that was removed; and a large medial femoral condyle flap that was removed and revealed a large 8 millimeter by 16 millimeter full thickness osteochondral defect. The defect was filled with two 8 millimeter osteochondral grafts from the intercondylar notch. The claimant treated postoperatively with immobilization, protective non weight bearing, activity modification, cryotherapy and rehabilitation with Dr..

Six weeks from surgery, on 02/03/10, Dr. noted full extension and 130 degrees flexion; 1+ effusion; quadriceps and hamstring strength of 5/5; and the claimant had remained non weight bearing with complaints of ongoing pain and occasional swelling. The claimant was progressed to weight bearing as tolerated and therapy was continued. On 02/22/10 Dr. recommended consideration of wearing a neoprene knee sleeve and one month trial of a transcutaneous electrical nerve stimulation unit for knee pain. The claimant continued to treat for the left shoulder as well. On 03/25/10 Dr. noted the claimant was using the electrical stimulation unit, had an eight degree left knee flexion contracture with motion from -8 to 103 degrees with quadriceps and hamstring strength of 4/5. Rehabilitation was continued. A request has been made for purchase of a transcutaneous electrical nerve stimulation unit.

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

ODG notes that a TENS unit is recommended as an option for claimants with osteoarthritis. This claimant has been noted diagnostically to have post traumatic arthrosis. Therefore, the reviewer finds that medical necessity exists for 2-LEAD TENS UNIT FOR PURCHASE.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates; Knee-TENS (Transcutaneous Electrical Nerve Stimulation)

Recommended as an option for patients in a therapeutic exercise program for osteoarthritis as a treatment for pain. The addition of TENS plus exercise appears to produce improved function (greater cumulative knee extensor torque, stride length, gait velocity and range of motion) over those treated with exercise only, although the difference has not been found to be significant. Transcutaneous electrical nerve stimulation offers clinically relevant short-term pain relief for osteoarthritis of the knee, according to a report in the June 22nd issue of BMC Musculoskeletal Disorders. Transcutaneous electrical nerve stimulation can help with short-term pain control among patients with hip or knee OA. A 6-week program of progressive strength training targeting the quadriceps femoris muscle group substantially improves strength and function following total knee arthroplasty for treatment of osteoarthritis, compared to patients who received standard of care therapy; however, addition of neuromuscular electrical stimulation (NMES) to the strength training exercise did not improve outcomes. There is no conclusive evidence that TENS reduces knee pain or physical

disability from osteoarthritis, even with years of clinical use and a plethora of clinical trials, based on a recent Cochrane Review, because the studies had poor methodological quality, inadequate reporting, and small sample size. Treatment responses -- however minimal -- occurred in 29 of 100 people treated with electrostimulation and in 26 of 100 people who had sham treatments or usual care.

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

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)