



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 05/03/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

TENS unit use for one month

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since 1993

REVIEW OUTCOME:

"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Medical necessity has not been demonstrated for use of a TENS unit.

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
722.11	E0730		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

1. Certification of independence of the reviewer and TDI case assignment.
2. TDI case assignment.
3. Letters of denial 04/16/10 & 03/08/10, including criteria used in the denial.
4. Designated doctor evaluation 10/20/09.
5. FCE 10/20/09.
6. Pain consultant documentation 01/21/10 – 03/23/10.
7. Evaluations 10/28/08 – 01/06/09.
8. Designated doctor exams 03/12/09, 07/08/09 & 10/20/09.
9. Radiology reports 03/20/09.
10. FCE 09/29/09.
11. Progress evaluation 09/29/09.
12. Rehab evaluation 07/28/98,
13. Hospital admission 10/24/08.
14. Nerve conduction study 03/26/09.
15. Physical therapy documentation 11/14/08 – 07/27/09.
16. Treatment notes 05/08/09 – 03/24/10.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual sustained an injury on xx/xx/xx, resulting in back and leg pain. MRI scan shows degenerative disc disease. EMG is unremarkable. A recent transforaminal epidural steroid injection was performed. Physical therapy has also been utilized.

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

ODG Guidelines criteria stipulate that a TENS unit may be useful for one month as an adjunct to other conservative care modalities for functional restoration. There is no indication that a coordinated plan is in place. Therefore, it is not reasonable to provide a TENS unit.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
 - Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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