

# Clear Resolutions Inc.

An Independent Review Organization  
7301 RANCH RD 620 N, STE 155-199A  
Austin, TX 78726  
Phone: (512) 772-4390  
Fax: (512) 519-7316  
Email: resolutions.manager@cri-iro.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/31/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

DME: Tens Unit w/electrodes

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Board Certified in Pain Management

**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**

Official Disability Guidelines

10/27/10, 11/24/10

Pain Institute 9/9/10 to 10/28/10

MD, PA 3/12/09 to 10/18/10

ODG-TWC 11/12/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man with low back pain since an injury in xxxx. He has been on several medications including the recently recalled Darvocet. It does not appear he had prior back surgery. The pain generator has been evaluated and the SI and facet joints are in consideration. MBB was denied. He had limited benefits from prior trigger point injections. He had no relief with a prior ESI. Dr. noted on 10/18/10 that his TENS unit was broken and was not functioning. This request is for replacement of his TENS unit.

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

The value of TNS units has been controversial. However, the ODG advises its use as an adjunct to other treatments for chronic back pain. It is not an isolated treatment. This claimant is no longer getting therapy and facet/MBB are advised but have been denied. The ODG describes TNS unit use as an adjunct to functional restoration. The records state this man continues to work and had prior therapy, so this criteria was met. The claimant had a trial period for its use and the unit provided benefit. Based on this information, the reviewer finds

there is medical necessity for the requested DME: Tens Unit w/electrodes. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

**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)