

SENT VIA EMAIL OR FAX ON  
Aug/26/2011

## IRO Express Inc.

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/26/2011

**IRO CASE #:**

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

Six month supply of electrodes

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

PMR

**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

1. Request for IRO 08/09/11
2. Utilization review determination 07/22/11
3. Utilization review determination 08/01/11
4. Clinical records Dr.
5. Notice of IRO decision 06/02/11
6. Clinical records Dr.
7. Treatment records DC
8. Letter of appeal 08/01/11
9. Clinical records Dr.
10. EMG/NCV study 07/02/97
11. Designated doctor evaluation 12/15/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who sustained work related injuries to his neck and shoulders on xx/xx/xxxx. Records indicate that the claimant has undergone multiple surgeries and has undergone hemiarthroplasty of both shoulders. The submitted clinical records indicate that the claimant has utilized an e-stem unit for years. Letters of appeal submitted by Dr. note that the claimant gets significant pain relief and utilizes the device one to two times per day. He's noted to be is currently being assessed to evaluate for possible shoulder replacement.

The request the initial request was reviewed by Dr. who notes that the claimant is using an RS4I muscle stimulator and reports no clinical information about his use of the stimulator is provided and notes there is no demonstration of functional benefit. She subsequently non-certifies the request.

The appeal request was reviewed by Dr. on 08/01/11 who reports that evidence based recommendation for TENS unit meets specific criteria and notes that the claimant is not post stroke and that there is no documentation regarding duration or frequency of use of the unit or documentation to establish efficacy. He opines this does not meet guidelines and subsequently non-certifies.

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

The request for 6 month supply of electrodes for the claimant's RS4I stimulator is medically necessary. There is sufficient data contained in the clinical record to establish the claimant receives benefit from these electrodes. Per Dr. notes, the claimant uses stimulator twice a day and sees significant pain relief and improvements in activities of daily living. As such, the request is medically necessary to provide continued pain relief and is appropriate to treat the condition.

**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)