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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/02/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMS Unit, Conductive Garment and Cer/Lum Cryo Therapy Unit with pad

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

M.D., Board Certified Physical Medicine and Rehabilitation

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 and Treatment Guidelines

Unimed Direct dated 02/10/12 and 03/21/12

Clinical records Dr. dated 10/10/97-12/20/11

Peer review dated 09/13/01

Clinical records Dr. 02/11/10, 03/11/10

Procedure report dated 03/11/10

Procedure report SI joint injection 03/25/10

Clinic note DPM dated 01/24/11

Clinic note Dr. DPM dated 05/04/11, 06/01/11

Clinic note Dr. dated 09/30/11

Clinic note Dr. dated 01/20/12

Letter of appeal CPC-H dated 02/07/12

Clinic note Dr. dated 02/15/12, 03/13/12

Procedure reports right SI joint injection 01/19/01

Procedure report right SI joint injection 11/16/01

Procedure report left SI joint injection 12/03/01

Procedure report left SI joint injection 12/14/01

Procedure report right medial joint blocks 12/10/03

Procedure report right medial joint blocks 12/17/03

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have date of injury of xx/xx/xx. On this date she is reported to have slipped and fallen on wet concrete. At the time of injury she was 9 months pregnant. She was subsequently transported to local ER where she was evaluated. She has been treated with oral medications, physical therapy, multiple SI joint injections, lumbar medial branch blocks, chiropractic, and physiotherapy. She has been followed by

pain management specialists to include Dr.. She received pain management from Dr. including treatment for left knee with intraarticular corticosteroid injections. Records indicate the claimant was seen by Dr. DPM who diagnosed the claimant with plantar fasciitis of medial band of left foot, plantar fibromatosis of left foot and gastrocnemius equinus of bilateral ankles. Records suggest the claimant later underwent a left knee arthroscopy and received additional SI joint injections.

On 01/20/12 the claimant was seen by Dr.. She presents for complaints involving cervical and lumbar spines and left knee. She reported complaints of stiffness, discomfort and shooting pains. She requested SI joint injections. It is reported the claimant requires MRI evaluation of her knee injury.

Current medications are reported to be Celebrex 200 mg, Tegretol XR 400 mg, Paxil 20 mg, Saphris 10 mg, Tramadol, Ibuprofen 800 mg, and multivitamin. Apparent requests were placed for electro muscle stimulation unit, cryo therapy unit and conductive garment. On 02/13/12 the claimant was seen by Dr.. There is no substantive change in claimant's physical status. She was most recently seen on 03/13/12.

The initial review was performed by Dr. on 02/07/12. Dr. notes there is no interval medical history or clinical patient assessment/SOAP notes submitted for review. He notes there was no documentation of what objectively defined pathology of occupational etiology is meant to be addressed by DME. He notes there is no documentation of recent surgery to support use of cryotherapy unit, and there is no documentation as to how patient is not able to use conventional methods of hot / cold application. He subsequently non-certified the request. The appeal request was reviewed by Dr.. Dr. non-certified the request noting the provided documentation did not include any clinical information to support the request. He notes the initial injury was over 16 years prior. He notes use of TENS or EMS would not be supported by clinical literature or treatment guidelines. He noted cryotherapy unit would not be medically necessary and subsequently non-certified the appeal request.

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

The available clinical record indicates the claimant had chronic complaints of neck, back, sacroiliac dysfunction, and knee pain as result of slip and fall occurring on date of injury. The submitted clinical records indicate the claimant has undergone extensive treatment to include oral medications, physical therapy, chiropractic treatment, and interventional procedures. The record does not contain any data establishing the claimant has undergone a trial of electrical stimulation with positive response. Additionally, it would be noted the most recent clinic note submitted by Dr. do not include detailed physical examination results that would support the need for electrical stimulation. Further, these requests are not generally supported in current evidence based guidelines for treatment of chronic myofascial pain. Based on the clinical information provided, the claimant would not meet current evidence based guidelines. The reviewer finds that the requested EMS Unit, Conductive Garment and Cer/Lum Cryo Therapy Unit with pad is not medically necessary.

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)