Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Oct/03/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
TENS Unit purchase

Wheel Chair Purchase

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified PM&R
Board Certified Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 07/03/13, 07/25/13
Scripts for TENS unit and wheelchair dated 06/18/13
Handwritten examination dated 06/07/13, 04/11/13, 07/03/13

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female whose date of injury is xx/xx/xx. On this date the patient was reaching for a ringing phone and slipped on wet carpet. The patient's right foot slipped back and her body fell on top of her leg with her left leg going forward and she hit her head on the floor causing her neck to pop forward then backward. Handwritten note dated 07/03/13 indicates that the patient needs a wheelchair to help improve her walking distance. She wants to walk as far as she can and start helping out in the grocery store. When she can no longer walk, she would like a wheelchair to help.

Initial request for TENS unit purchase/wheelchair purchase was non-certified on 07/03/13 noting that ODG does not recommend these treatment modalities secondary to lack of effectiveness for low back pain. The details of the patient's diagnoses are not clear. There are no indications for TENS and wheelchair. Claimant should perform active daily gentle exercise. The denial was upheld on appeal dated 07/25/13 noting that the request for TENS

unit does not comply with ODG criteria, and although ODG does not address the purchase of a wheelchair, there is no medical necessity for a wheelchair for an ambulatory individual.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The patient sustained injuries on xx/xx/xx, however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient reportedly has utilized a TENS unit before; however, the patient's objective, functional response to this treatment is not provided to establish efficacy of treatment and support the requested TENS purchase. There are no specific, time-limited treatment goals provided. The Official Disability Guidelines do not support the use of TENS for treatment of chronic low back pain as there is strong evidence that TENS is not more effective than placebo or sham. It is unclear why the patient requires a wheelchair when she is ambulatory. As such, it is the opinion of the reviewer that the request for TENS unit purchase/wheelchair purchase is not recommended as 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)