

# Clear Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jun/18/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** TENS unit, electrodes x 2 and conductive garment (purchase) - lumbar

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

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the request for TENS unit, electrodes x 2 and conductive garment (purchase) - lumbar is not recommended as medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 04/15/13, 05/02/13, 04/10/13

Letter dated 04/02/13

Certificate of medical necessity and prescription dated 03/20/13

Script dated 03/2013

Office note dated 03/11/13, 03/07/13, 03/05/13, 03/08/13, 03/15/13, 04/05/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. Treatment to date includes a course of physical therapy. Note dated 03/08/13 indicates that the patient has been using a TENS unit both during therapy and at home as needed. However, that unit was given in 1993 and appears to be malfunctioning. Diagnoses are listed as thoracic strain/sprain, lumbosacral strain/sprain, and sacroiliac joint pain. Follow up note dated 04/05/13 indicates that the patient complains of low back pain, muscle spasms, cramping and pain down the left leg with numbness and tingling. The patient states that overall she feels better. She did get the TENS unit that is helping. She uses it periodically during the day. She is still working modified duty. On physical examination motor examination is 5/5 in the right lower extremity throughout and 5-/5 in the left lower extremity throughout. Sensation is subjectively decreased to light touch and pinprick along the lateral aspect of the left foot involving the great toe. Deep tendon reflexes are symmetrical at 1+ patella and 0 Achilles bilaterally. Gait is normal.

Initial request for TENS unit, electrodes x 2 and conductive garment purchase-lumbar was non-certified on 04/15/13 noting that ODG guidelines do not recommend use of TENS as an isolated intervention. There is no evidence of a trial of use of TENS with objective clinical

benefit. There is inadequate reason for home use of TENS. The supplies and conductive garment are not medically necessary in the absence of necessity for the TENS unit. The denial was upheld on appeal dated 05/02/13 noting that the reference does not provide any data to support an expectation that the requested piece of durable medical equipment would be expected to enhance functional abilities on a long term basis for the described medical situation.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on 01/16/2013 and has completed a course of physical therapy. The patient is noted to have utilized a TENS during therapy and at home; however, there are no objective measures of improvement documented to establish efficacy of treatment. There are no specific, time-limited treatment goals provided. The Official Disability Guidelines note that TENS units are not generally recommended for the treatment of chronic low back pain as there is strong evidence that TENS is not more effective than placebo or sham. As such, it is the opinion of the reviewer that the request for TENS unit, electrodes x 2 and conductive garment (purchase) - lumbar 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

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)