

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/09/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: purchase of TENS unit

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and 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 this reviewer that the request for purchase of TENS unit is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his left thumb and wrist. The injury occurred on xx/xx/xx. The clinical note dated 12/16/13 indicates the patient complaining of 8/10 pain at the left wrist and thumb. The MRI of the left wrist dated 12/23/13 indicates the patient having moderately severe DeQuervain's syndrome. A TFCC injury was identified with obliquely oriented tearing of the ulnar half of the triangular fibrocartilage. An ulnar subluxation was identified with superficial tearing and tenosynovitis of the extensor carpi ulnaris tendon. The clinical note dated 07/25/14 indicates the patient complaining of numbness at the dorsal region of the left thumb. The patient also reported difficulty with bending the left thumb as well. The patient reported mild motion restrictions at the left hand with a minimal loss of grip strength. Mildly frequent aching pain was also identified at the left wrist. Tenderness was evident at the left wrist as well. The patient was able to demonstrate a normal level of reduced motion. The note indicates the patient utilizing Ibuprofen for pain relief. The clinical note dated 08/13/14 indicates the patient having complaints of neuropraxia. No significant changes were identified in the patient's clinical presentation from the previous note.

The utilization review dated 07/01/14 resulted in a denial for a TENS unit as no objective measurements were identified confirming the efficacy of the treatment.

The utilization review dated 08/06/14 resulted in a denial as the primary complaints for the patient at that time were numbness at the left thumb which will not result in a significant reduction with the use of a TENS unit.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of numbness at the left hand and thumb. The use of a TENS unit is generally not recommended at the forearm, wrist, and hand as no scientifically proven findings confirming the safety and efficacy of the use of a TENS unit for the treatment of acute hand, wrist, or forearm symptoms has been confirmed. Additionally, no objective data was submitted in the documentation confirming the patient's functional deficits at the left wrist and thumb. Therefore, it is unclear if the patient would benefit from the use of a TENS unit. Without the necessary information in place, this request is not fully indicated. As such, it is the opinion of this reviewer that the request for purchase of TENS unit is not recommended as medically necessary and the prior denials are upheld.

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 KNOWLEDGBASE

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)