

Applied Assessments LLC

An Independent Review Organization

2771 E. Broad St. Ste. 217 PMB 110

Mansfield, TX 76063

Phone: (512) 333-2366

Fax: (512) 519-7997

Email: admin@appliedassessments.net

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Aug/26/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

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

Board Certified PM&R

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury to her mid back. No information was submitted regarding initial injury. The MRI of the thoracic spine dated 10/23/13 revealed essentially unremarkable assessment without mass effect on the cord. The spinal cord was identified as having normal size, signal, and shape throughout the thoracic spine. A clinical note dated 06/18/14 indicated the patient complaining of ongoing low back pain rated 8-9/10. Therapy note dated 07/31/14 indicated the patient completing four physical therapy sessions to date. The patient was doing a home exercise program including aquatic therapy and land based activities.

The utilization review dated 07/23/14 resulted in a denial for TENS unit as no as insufficient information had been submitted regarding any identifiable or treatable pathology. Clinical utilization review dated 08/04/14 resulted in denial for TENS unit as no clinical insufficient clinical information had been submitted.

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

The patient complained of mid and low back pain. TENS unit is indicated for patients with continued symptoms indicating significant functional deficits. There is an indication the patient has continued mid and low back pain. However, no information was submitted regarding any significant functional deficits likely to benefit with the use of a TENS unit. Additionally, it is unclear if the patient has completed a one month trial of a TENS unit resulting in objective functional risk improvement as. No objective data was submitted

regarding ongoing functional deficits. Therefore, given these factors the request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for a TENS unit for rental or 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

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)