

Applied Resolutions LLC
An Independent Review Organization

Phone Number:
(817) 405-3524

900 N Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063

Fax Number:
(817) 385-9609

Email: appliedresolutions@irosolutions.com

Notice of Independent Review Decision

Case Number:

Date of Notice: 07/13/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Physical Medicine And Rehab

Description of the service or services in dispute:

RT300 Functional Electrical Stimulation (FES) Cycle Rehabilitation System

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)

Patient Clinical History (Summary)

The patient is a xx year old who initially presented with findings consistent with paraplegia as a result of an explosion xx/xx/xx. The MRI of the lumbar spine dated 11/26/14 revealed a severe compression fracture at L1 with a fracture of the posterior pedicles bilaterally. An anterior listhesis measuring 9mm was identified of T12 on L1 with facet subluxation. Cord compression was identified with a partial laceration. Central canal stenosis was also identified at L1 and a tear of the interspinous ligaments was identified between T12 and L1. The operative note dated 11/27/14 indicates the patient undergoing treatment at the T12-L1 level with a laminectomy at L1 and a spinal fusion from T11 through L3. The patient also underwent an intermedullary nailing at the right femur as well. The therapy note dated 05/09/15 indicates the patient undergoing ambulatory retraining. The focus of the training was to enable a patient to complete his activities of daily living. The patient was currently in a wheelchair but was able to use a walker within his home setting. The patient was identified as having diminished sensation and strength in the lower extremities. The clinical note dated 05/19/15 indicates the patient being recommended for the RT300-SL motorized FES cycle ergometer for the lower extremities in order to continue with the patient's retraining. The clinical note dated 05/29/15 indicates the patient having completed 4 lower extremity FES cycling sessions as part of the ongoing rehabilitation program. The patient had demonstrated good compliance and tolerance for the proposed treatment. There is an indication the patient's musculature was producing stronger contractions with the continued use of the device. The clinical note dated 06/01/15 indicates the patient having completed more than 20 physical therapy sessions to date. The patient was continuing with findings consistent with spasticity, spasms, edema, neuropathic pain, neurogenic bowel, and neurogenic bladder. The note indicates the patient

able to ambulate 521 feet. The patient reported near complete exhaustion following ambulation of that distance. The letter of appeal dated 06/18/15 indicates the patient continuing to be recommended for the use of the RT300 FES cycle therapy system.

The utilization reviews dated 05/22/15 & 06/15/15 resulted in denials as insufficient information had been submitted confirming the patient's completion of all conservative treatments to include a 32 session physical therapy program complete with the proposed device over a 3 month period.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The documentation indicates the patient having sustained a spinal cord injury resulting in significant functional deficits in the lower extremities. The use of a functional electrical stimulation device is indicated for patients who have demonstrated significant functional capabilities within the formal therapeutic setting with ongoing functional deficits. There is an indication the patient has been utilizing the RT300 FES device with some improvements. However, it is unclear if the patient has completed a full 32 therapeutic session program complete with the use of the device over a 3 month period. Given the lack of information confirming the patient's completion of a 32 physical therapy session program with the device leading to an objective functional improvement to include range of motion and strength within the lower extremities, it is unclear if the patient will fully benefit from the proposed treatment. Therefore, the request is not indicated. As such, it is the opinion of this reviewer that the request for the RT300 functional electrical stimulation cycle rehabilitation system 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 and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)