

Clear Resolutions Inc.

An Independent Review Organization

6800 W. Gate Blvd., #132-323

Austin, TX 78745

Phone: (512) 879-6370

Fax: (512) 519-7316

Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/08/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Durable Medical Equipment (DME); Purchase of NMES (Neuromuscular electrical stimulation) and TENS (transcutaneous electrical nerve stimulation) Units

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

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 Durable Medical Equipment (DME); Purchase of NMES (Neuromuscular electrical stimulation) and TENS (transcutaneous electrical nerve stimulation) Units is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is a male. On XX/XX/XXXX, he was seen in clinic for complaints of neck and back pain. It was noted that despite the use of modalities and therapy, his symptoms were not responding as expected. It was noted that physical therapy and aquatic therapy were being done on a regular basis. A prescription for DME purchase was submitted at that time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a utilization review determination letter was submitted for the requested neuromuscular stimulator and noted the request was non-certified. It was noted that without objective documentation of a positive response to a prior trial of neuromuscular electrical stimulation device, TENS and without evidence that the devices would be used as an adjunct to a program of evidence based conservative care such as formal physical therapy, the request would not be warranted. Guidelines utilized were the Official Disability Guidelines low back chapter.

On XX/XX/XX, a utilization review report for the requested purchase of an NMES and TENS units, noted the request was non-certified. It was noted there was a lack of positive response during physical therapy with a trial use of the units, to support the medical necessity of purchase for home units. The previously non-certified request was upheld.

It is the opinion of this reviewer that the request for Durable Medical Equipment (DME); Purchase of NMES (Neuromuscular electrical stimulation) and TENS (transcutaneous electrical nerve stimulation) Units is not 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 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)