



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:
877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 12/15/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMPI Select TENS unit purchase

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

Board Certified in Orthopedic Surgery

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 or not medical necessity exists for each of the health care services in dispute.

EMPI Select TENS unit purchase - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An emergency room report from an unknown provider (signature was illegible) on 02/12/10

X-rays of the cervical and lumbar spines interpreted by M.D. dated 02/12/10
Evaluations with, P.A-C. dated 03/25/10, 04/08/10, 04/22/10, and 05/06/10
An MRI of the lumbar spine interpreted by M.D. dated 04/05/10
Evaluations with M.D. dated 06/16/10, 06/28/10, 08/25/10, and 10/25/10
Evaluations with M.D. dated 07/21/10 and 09/13/10
Procedure notes with Dr. dated 08/02/10 and 09/08/10
An evaluation with F.N.P. dated 08/10/10
A physical therapy evaluation with an unknown therapist (signature was illegible) dated 09/24/10
DWC-73 forms from Dr. dated 10/05/10 and 12/08/10
A prescription for a TENS unit from Dr. dated 10/13/10
A statement of medical necessity from Dr. dated 10/18/10
A physical therapy progress note from the unknown therapist dated 10/25/10
A letter of non-certification, according to M.D. dated 11/01/10
A letter of non-certification for a TENS unit, according to the Official Disability Guidelines (ODG), from M.D. dated 11/24/10
The ODG Guidelines were provided by the carrier/URA

PATIENT CLINICAL HISTORY

X-rays of the cervical and lumbar spine interpreted by Dr. on 02/12/10 showed minimal retrolisthesis at L5-S1 and minimal spondylolisthesis at L4-L5. On 03/25/10, Ms. requested a lumbar MRI, Flexeril 10 mg., and work restrictions. An MRI of the lumbar spine interpreted by Dr. on 04/05/10 showed questionable canal stenosis only in part at T10-T11, primary spondylolisthesis at L4-L5, and a 2.4 cm. right adnexal mass. On 04/22/10, Ms. recommended a thoracic MRI and increased work duties. On 06/16/10, Dr. performed a steroid injection in the right paralumbar muscles. Lumbar epidural steroid injections (ESIs) were performed by Dr. on 08/02/10 and 09/08/10. On 09/13/10, Dr. recommended a return to full work duty, physical therapy, and a third ESI. On 09/24/10, physical therapy was recommended three times a week for four weeks. On 10/18/10, Dr. wrote a prescription for an EMPI 4 lead TENS unit and supplies. Dr. wrote a letter of non-certification for a TENS unit purchase on 11/01/10. On 11/24/10, Dr. wrote a letter of non-certification for the EMPI TENS unit purchase.

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

The requested TENS unit purchase is neither reasonable nor necessary. The Official Disability Guidelines (ODG) does endorse the use of TENS units for approximately one month's time transitioning the patient into an acute treatment program. The current medical literature does not demonstrate efficacy of such a unit in the treatment of chronic pain. The ODG specifically limits the use of a TENS unit to the first month of treatment and thereafter it is indicated to be neither reasonable nor necessary. At this time, the fact that the TENS unit is showing efficacy may well indeed be a placebo response. Therefore, the requested EMPI Select TENS unit purchase is neither reasonable nor necessary and the previous adverse determinations should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE
- 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

X 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)**