October 30, 2002

Re: Medical Dispute Resolution
MDR #: M2.02.0846.01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Pain Management and Anesthesiology.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

Client History:
This female patient suffered an on-the-job injury on ___. She completed a chronic pain management program on 02/15/02 with a pain level of 4-5/10. She returned for follow-up on 04/05/02, complaining of low back and pelvic pain at a level of 4/10. She was taking hydrocodone 5 mg b.i.d., Keppra 500 mg b.i.d., Celebrex and Skelaxin.

Disputed Services:
Purchase of RS-4i sequential stimulator.

Decision:
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the medical equipment requested is not medically necessary in this case.

Rationale for Decision:
No clear objective evidence exists of significant benefit from this patient's use of this device. There are no peer-reviewed, scientific studies demonstrating long-term efficacy of this device for patients with the clinical condition described in this case. It is generally accepted medical standard that active exercise is preferable to passive modalities, especially when the application of passive modality is being considered 15 or 16 months following the injury.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on October 30, 2002.

Sincerely,