

January 21, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-03-0496-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on \_\_\_ external review panel. This physician is board certified in physical and rehabilitative medicine. \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 45 year-old male who sustained a work related injury on \_\_\_. The patient reports that he works as a maintenance person. He reports that he was working and bending, lifting and doing repairs on \_\_\_ when he experienced severe lower back pain. The patient had extensive work-up and rehabilitation with various diagnoses suggested. He was found to have an L4-L5 central disc protrusion with moderate spinal canal stenosis. He received various medications, epidural injections, spinal manipulations, traction and bracing. The patient underwent L3-L5 anterior posterior fusion with ICBG 10/29/02 and was in an inpatient rehabilitation program from 11/6/02 through 11/18/02. Per the discharge summary the patient had a good surgical result. The patient was to start therapy on 1/3/03..

### Requested Services

The purchase of a BMR Neuromuscular Electrical Stimulator.

### Decision

The Carrier's denial of authorization for the requested services is upheld.

### Rationale/Basis for Decision

\_\_\_ physician reviewer indicated that the patient underwent surgery on 10/29/02 followed by post-op rehabilitation. \_\_\_ physician reviewer explained that the documents provided for review did not indicate that patient had a successful supervised trial of the neuromuscular electrical

stimulator. \_\_\_ physician reviewer also explained that the medical documents provided did not indicate that the patient had used or needed the requested neuromuscular electrical stimulator in the post-operative period, or in the period following his discharge from rehabilitation. \_\_\_ physician reviewer further explained that the documents provided did not show medical necessity for the neuromuscular electrical stimulator. Therefore, \_\_\_ physician consultant concluded that the BMR Neuromuscular Electrical Stimulator is not medically necessary to treat this patient's condition.

This decision is deemed to be a TWCC Decision and Order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the 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 **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

**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 **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) 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. (Commission Rule 133.308(t)(2)).

Sincerely,

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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 this 21st day of January 2003.