

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-2380.M2

February 4, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0548-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Neurology. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

Review of the records available reveals that ___ was a 45-year-old gentleman who injured his lower back at work on ___. He eventually had back surgery on 8/28/02 consisting of a laminectomy, left foraminotomy at L4/5 and L5/S1, lateral fusion at L3/4 and removal of posterior segment instrumentation by ___. He began using a neuromuscular stimulator on 9/19/02 prescribed by ___. The last report available from ___ is dated on 10/23/02 with diagnosis of surgical procedure. He provided him with Norco tablets and recommended follow-up in three months with x-rays. He was to remain at no work status.

REQUESTED SERVICE

The purchase of a Neuromuscular Stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

There is an article from ___ and ___ entitled “Combined Neuromuscular electrical Stimulation and Transcutaneous Electrical Nerve Stimulation for Treatment of Chronic Back Pain: a Double Blind, Repeated Measures Comparison.” This study was performed on 24 chronic back patients and this study showed the combined neuromuscular stimulator and TENS unit produced greater pain reduction and pain relief than placebo, TENS unit, or neuromuscular stimulation. The neuromuscular stimulator, although less effective, did produce as much relief as a TENS unit. They recommended further research investigating the effectiveness of both the neuromuscular stimulator and combined neuromuscular stimulator/TENS unit.

A computerized medical search does not reveal evidence of peer review literature of the chronic effectiveness of long-term neuromuscular stimulation for chronic back pain. The reviewer is unable to recommend the purchase of a neuromuscular stimulator based on the lack of peer reviewed literature or studies supporting the use of a neuromuscular stimulator alone for chronic back pain. There is no long-term double blind peer review study indicating efficacy and safety of this device for this condition.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee’s policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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 Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 4th day of February 2003.