

NOTICE OF INDEPENDENT REVIEW DECISION

February 6, 2003

RE: MDR Tracking #: M2-03-0557-01
IRO Certificate #: IRO 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This patient sustained a work-related injury on ___ when she fell and landed on her knee. She twisted her body and also complained of back pain. The patient was evaluated at ___ on 05/23/01, at which time x-rays were performed. The left hip, right knee, right ankle, pelvis and left hand x-rays were all performed and deemed normal. The patient followed up with an allopath on 05/30/01, who prescribed medications. The patient also began a rehabilitation program. The patient also began chiropractic care which consisted of daily care. An MRI performed on the right knee on 06/27/01 revealed a minimal sprain with no derangement and a Grade I chondromalacia patella. On 09/21/01, the patient underwent a lumbar MRI that revealed a disc bulge at L4-5 with no evidence of herniation. An orthopedic surgeon was consulted on 11/27/01, who recommended the possibility of surgery to the right knee and prescribed Ultram. A second orthopedic surgeon was consulted on 01/02/02, who did not agree with the need for surgery especially since the MRI study was negative for derangement. A third orthopedic surgeon was consulted, who performed surgery on 05/15/02. The surgery included knee arthroscopy, resection of the synovium, synovectomy and chondroplasty. Post-operative therapy was begun and by 06/20/02, the patient was noted to have full range of motion in extension and 120 degrees of flexion. There was no evidence of effusion. On 09/12/02, the patient was

documented to have full flexion and extension, no instability, no positive orthopedic tests, and no effusion. The knee was pronounced stable. Maximum medical improvement was deemed on 10/10/02 and a whole person impairment was awarded at that time.

Requested Service(s)

A NT2000 neuromuscular stimulator.

Decision

It is determined that the NT2000 neuromuscular stimulator is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

There is no documentation to suggest that this patient's condition is permanent or will require permanent application of this passive modality. This patient has undergone an extensive amount of passive care to date and the documentation does not support the need for permanent application or delivery of additional passive care. In addition, orthopedic follow-up examinations suggest that this patient's knee is stable, that no positive orthopedic tests are present, full ranges of motion have been achieved, and no swelling is present. Given these factors, it is unreasonable to expect that this patient would need permanent home delivery of this passive modality. Lastly, there is no peer-reviewed literature to suggest that the permanent use of passive modalities is medically necessary to treat soft tissue injuries. Conversely, there is evidence to suggest that the permanent use of passive modalities fosters chronicity and increases the dependence on provider driven care. Therefore, it is determined that the NT2000 neuromuscular stimulator is not medically necessary.

This decision by the IRO 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** (10) 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).

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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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), 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 6 th day of February 2003.
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