

April 29, 2003

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

MDR Tracking #: M2-03-0871-01
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 in occupational medicine and board certification in family practice. 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

There was no information submitted regarding ___ injury, care and treatment. There is a diagnosis of lumbar strain on one of the letters from ___. Among documents presented for review included letters from ___, dated 1/15/03 and 2/6/03. The report of 1/15/03 is by ___, and was a response to the request for the BMR NT 2000 neuromuscular stimulator. The report shows that the physician reviewer states that he is not aware of any controlled studies indicating the efficacy of such a device. Therefore, the request for the purchase of this device was not certified. The letter of 2/6/03 by ___, states that ___ was unable to certify the reconsideration. He stated that he attempted to contact ___ on 2/6/03 and left message to discuss the request, but got no response. It was stated that ___ had used the unit for several months and had gained maximum therapeutic benefit. He was no in an ongoing active rehab and additional gains and benefits could be expected. The purchase of the neuromuscular stimulator was not certified.

Also included for review were reports from STAT 2000 dated 10/16/02, 1603 and 1/10/03. There was a summary of a study entitled Combined Neuromuscular Electrical Stimulation and Transcutaneous Electrical Nerve Stimulator for Chronic Back Pain: A Double-blind, Repeated Measures Comparison from the Official Journal of the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation.

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

The synopsis from the study from the Official Journal of the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation shows that the conclusion states that the combined NMES/TENS treatment consistently produced greater pain reduction and pain relief than placebo, TENS, or NMES. NMES alone, though less effective, did produce as much pain relief as TENS. Although preliminary, this pattern of results suggests that combined NMES/TENS may produce a valuable adjunct in the management in chronic back pain. However, of significance, is the note that the article states that further research investigating the effectiveness of both NMES and combined NMES/TENS seems warranted. Therefore, the reviewer is unaware of any controlled study indicating the efficacy of such a device.

Based on the above information, the reviewer finds no rationale for the medical necessity of the proposed purchase of the neuromuscular stimulator.

___ 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 29th day of April 2003.