

May 1, 2003

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

MDR Tracking #: M2-03-0876-01
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 Physical Medicine and Rehabilitation. 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

___, while working at ___, injured her right arm on ___. For two years she was treated with medications, restricted activities and therapies that provided little relief from pain, spasms and edema. She was provided at trial use of the BMR MT 2000 neuromuscular stimulator and when evaluated approximately seven weeks later was found to have diminished pain and spasms – from a 7 to a 3. According to the records provided, she was sleeping better and using less medication. Her ROMs had improved. ___ was released to return to work, and was wanting this unit to allow her to function at that level that she had been able to achieve. A request was made for permanent purchase of this equipment. A peer review by ___, dated 2/13/03, determined that there was no objective assessment of current functional abilities or limitations, nor any other clinical information to indicate that the device would work indefinitely.

REQUESTED SERVICE

The purchase of a neuromuscular stimulator is requested for this injured worker.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer is aware that the use of this device remains controversial among medical authorities, however, in this instance, the patient had a problem for almost two years, was

provided with a neuromuscular stimulator, and improved over a period of 45 days. This was a clear indication of a response to treatment. This patient's response to a trial of treatment with the BMR MT 2000 is an indication of the medical necessity for the purchase of a 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 1st day of May 2003.