

MDR Tracking Number: M2-03-1261-01
IRO Certification# 5259

June 25, 2003

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

This gentleman was injured on ____. On April 21, 2003 there was a request for the purchase of an RS4i stimulator. The pre-authorization reviewer denied this request. A reconsideration request was made and again denied. An RME evaluation was completed by ___ on February 20, 2003 and ___ noted that three separate surgeries to the lumbar spine were completed. At the current time chronic pain continues to be the primary complaint. A moderate loss of range of motion, consistent with three surgeries, was noted. ___ suggested an assessment to determine if there was a pseudoarthrosis. ___ continued to treat the chronic pain and noted to a point specific area of pain corresponding to the site of the instrumentation. The progress notes indicate no change (specifically decrease) in the medication usage.

REQUESTED SERVICE (S)

Purchase RS4i stimulator

DECISION

Uphold denial – endorse the prior determinations

RATIONALE/BASIS FOR DECISION

Based on the medical records provided, there is no indication of a trial of this device, if this device has any efficacy whatsoever and any discussion of how this device would restore a pain free existence. Further, there is a question of an additional surgery and the records reflect the pain generator as a function of the hardware. Moreover, this type of device is for use in the acute phase, and the date of injury is more than twelve years ago. The Philadelphia Study noted that this type of device offers nothing more than a placebo effect, and with there being no notation of any decrease in the use of oral analgesics, the purpose of this device is obviated. Lastly, there needs to be some identification of an active participation on the part of the claimant in his own care. To rely solely on passive measures when the literature is quite clear that active measures are better suited for this type of rehabilitation would be an additional indicator that this implement is not reasonable and necessary care for this injury and not warranted.

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) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

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) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

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 26th day of June 2003.