

July 7, 2003

MDR Tracking #: M2-03-1310-01  
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

This patient is a 58-year-old female who became dizzy, stepped backwards and fell down some stairs on \_\_\_. After falling, she complained of low back pain and pain in the occipital area where she hit. She remained dizzy after the fall and had x-rays and a CT of the head that were reported as without fractures and unremarkable. Because she continued to have low back and left leg pain, she was seen by \_\_\_ who recommended medications, restricted activity, therapies and a lumbar MRI. On 9/6/02 the lumbar MRI was read as mildly bulging discs at several levels without neurocompression. She was referred to \_\_\_ for lumbar ESIs when she continued to have lumbar pain that radiated down her left leg. She did not see \_\_\_, but was sent back to \_\_\_ on 1/28/03 for an impairment rating. An EMG/NCS was requested, she was taken off work and a referral to \_\_\_ was again made. On 3/1/03 \_\_\_ saw \_\_\_ and recommended L. lumbar facet and L. SI injections. On 3/4/03 she underwent the above injections. She did not have relief of her pain. On 4/23/03 \_\_\_ requested an interferential/neuromuscular stimulator (RS-4i Sequential stimulator 4-channel) be purchased to reduce myofascial pain and increase activities and reduce medication use. He reported that she had a good response to the device. The carrier declined coverage based on the recommendations of two physicians on 5/1/03 and 5/14/03. The carrier's basis of denial is stated as no scientific evidence for the requested services, and passive modality is inferior to active exercise, and lack of peer to requestor contact.

#### REQUESTED SERVICE

The purchase of an RS-4i sequential stimulator/4-channel interferential and muscle stimulator is requested for this patient.

## DECISION

The reviewer disagrees with the prior adverse determination.

### BASIS FOR THE DECISION

The patient's reported response of decreased pain, decreased use of medications and increased ability to sleep are the main reasons for the unit to be considered medically necessary. From the medical records provided, the requestor was able to demonstrate the unit's efficacy by trial of use.

\_\_\_ 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 \_\_\_, dba \_\_\_, 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).