

August 12, 2003

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

MDR Tracking #: M2-03-1553-01
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 Occupational Medicine. 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

___ is a 61-year-old gentleman who sustained a severe laceration to the right wrist when a transmission fell on his wrist at work in ___. He apparently lacerated quite a bit of soft tissue in the area, especially the area of the right ulnar nerve. He had initial repair of the wound soon after the injury. In November of 1998 he was sent for electrodiagnostic studies of his right wrist and hand. The findings at that time were compatible with ulnar neuropathy with the injury at the site of the trauma. He then underwent surgical repair of the ulnar nerve with grafting. He continued with numbness and parasthesias over the medial aspect of the hand with significant weakness in the ulnar intrinsics.

___ was then seen by ___ for an apparent Determination of MMI. ___ stated that this patient had not reached MMI. The patient was then seen by ___ who referred him to ___, a pain management specialist who requested a one-month trial of a TENS unit.

___ had his records reviewed by ___. He was subsequently seen by ___ on 11/15/00 who stated that this patient had reached statutory MMI on 8/11/00 and gave him fourteen percent (14%) whole person impairment.

REQUESTED SERVICE

The trial rental of a TENS unit for one month is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

It should be noted that ____, pain management, mentioned the rental of the TENS unit for one month on the visit of 5/29/03, almost five years after the date of injury. Review of the medical records show that this patient apparently had a severe injury and underwent surgeries and different treatment modalities, including medications to include Neurontin and Elavil. ____ stated on his note of 5/29/03 that he could even be a candidate for a trial of spinal cord stimulation. Therefore, ____ appears to be trying every treatment option available, including a TENS unit.

The book, Clinical Orthopaedic Rehabilitation, Second Edition, by Dr. S. Brent Brotzman and Kevin E. Wilk, states that a TENS unit is designed to help control pain or dysfunction as well as reflexogenic and autonomic physiologic responses to noceioception. They point out that various modes can be of benefit to a patient. The conventional mode of TENS relieves pain through a proposed spinal cord unit mechanism. It is designed to provide a comfortable tingling sensation at a submotor level. They note the mode's perimeter ranges. They state that mode may be used in both acute and chronic conditions with relatively fast results in pain modulation. The actual treatment plan varies depending on the patient and the condition. With the conventional mode, adaptation to the stimulus is common and a continuous modification of the pulse width and pulse rate may be necessary to maintain the perceived parasthesias by the patient.

Since ____ saw ____ with significant problems from his injury of almost five years prior, and because ____ wanted to try the available treatment options, including a TENS unit, the reviewer finds that the proposed trial rental of the TENS unit for one month is appropriate.

It should be noted that this request is not for the purchase of this device.

____ 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 12th day of August 2003.