

August 21, 2003

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

MDR Tracking #: M2-03-1557-01  
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

Complete medical records were not available, but according to documentation \_\_\_ is age 39 as of today. He suffered a work-related injury to his low back on \_\_\_. The records available do not indicate the diagnostic nature of the injury, imaging studies, nor response to other therapies. There are two letters dated May 2003 from \_\_\_; both include requests concerning the muscle stimulator.

#### REQUESTED SERVICE

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

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

There is inadequate medical evidence in the records to justify the purchase of this unit for this patient in this case. The diagnosis listed on the 5/6/03 letter was that of "lumbago." Diagnosis on the March original prescription for the unit was that of "low back pain," indicating treatment had included therapy, medications, and surgery, though the specifics were not listed.

This case had also been reviewed on 5/14/03 by a physician adviser who judged that there was insufficient documentation concerning beneficial response with the stimulator, including no evidence of reduction in medical services, improved function, etc. and mention that the stimulator should not be used “as substitute for a home exercise program.” A June 2003 verbal opinion denial by another reviewer, \_\_\_\_, also noted insufficient evidence to justify the purchase of the unit and no records to indicate sufficient compliance by the patient with a good home exercise program, etc.

Considering all of the above, the \_\_\_\_ reviewer also recommends at this time disapproval for the purchase of the RS-4i interferential muscle stimulator in this case.

\_\_\_\_ 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 21<sup>st</sup> day of August 2003.**