

August 26, 2003

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

MDR Tracking #: M2-03-1673-01  
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

\_\_\_ is a 51-year-old woman who sustained a repetitive motion work injury on \_\_\_ subsequently resulting in bilateral carpal tunnel releases. Her treating doctor recommended use of the RS-4i sequential stimulator, a 4-channel combination interferential and muscle stimulator unit to improve function and decrease pain. There is a note from \_\_\_ indicating the medical necessity for the device in that the patient did improve function and decrease use of medication. There were no medical notes provided that show there was any improvement, or details of how much the use of medication was decreased, or what medicines she was taking. The carrier, on the other hand, had contacted \_\_\_ office and \_\_\_ has provided an opinion that the ongoing full-time use of the RS-4i unit was not indicated or medically necessary. There is also a letter from \_\_\_ who that stated that the long-term use of the unit was not medically necessary.

#### REQUESTED SERVICE

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

#### DECISION

The reviewer agrees with the prior adverse determination.

## BASIS FOR THE DECISION

The carrier provided two orthopaedic surgeons' opinions that the requested device was not medically necessary. The treating doctor has supplied a standard statement that the unit helped the patient, but failed to include specific notes that indicate the patient's increased function with the use of the unit during the two-month trial period. The treating doctor did not provide information about what medicine and how much medication the patient was taking, or how much the medications were reduced with the use of the unit. Therefore, the reviewer finds that the treating doctor did not substantiate the medical necessity for the need of the purchase of an RS-4i sequential 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).