

September 23, 2003

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TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-03-1753-01
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 reviewer is on the TWCC Approved Doctor List (ADL). 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

The information available for review shows the patient's diagnosis on the note of 7/14/03 to be ulnar nerve lesion and carpal tunnel syndrome. The progress note of 6/19/03 also shows a diagnosis of lateral epicondylitis.

There was no information provided that stated the origin of ___' injury. However, it appears that she had three steroid injections to the area of the lateral epicondyle. She was treated with a tennis elbow strap, stretching, anti-inflammatory medication and physical therapy. Subsequently she underwent surgery for lateral epicondylar debridement and thereafter had some complaints that showed the diagnoses of ulnar nerve injury and carpal tunnel syndrome. In addition to the medications, the injections and surgery, she was also treated with physical therapy.

REQUESTED SERVICE

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

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

It is noted that there is a prescription for two months use of the requested device. There is also a prescription for an indefinite use of the interferential and muscle stimulator dated 6/17/03. Even though there is a note from ___ dated 6/19/03 that ___ had increased function due to decreased pain, there is no mention on the progress notes or on the physical therapy notes of the use of the interferential and muscle stimulator or its results.

Even though there is a study published in The Journal of Pain, Vol. 2, No. 5 (October), 2001:pp 295-300, entitled Electrical Muscle Stimulation as Adjunct to Exercise Therapy in the Treatment of Non-acute Low Back Pain, A Randomized Trial, this study was done with individuals with low back pain. The study sample was small and the electrical stimulation appeared to have been discontinued after two months.

Therefore, there are no significant studies to indicate significant improvement in function or decreased utilization of medications associated with the use of an interferential and muscle stimulator. Based on the above information, the reviewer finds that there is no documentation to support the medical necessity of the proposed purchase of the interferential and muscle 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 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 (28 Tex. Admin. Code 142.5(c)).

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 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787

Austin, Texas 78744
Fax: 512-804-4011

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

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 23rd day of September 2003.