



Texas Medical Foundation

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phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

October 15, 2003

Requestor

RS Medical
Attn:
P.O. Box 872650
Vancouver, WA 98687-2650

Respondent

Old Republic Insurance Company
Attn: Dalene Martin
P.O. Box 219011
Dallas, TX 75221-9011

RE: Injured Worker:
MDR Tracking #: M2-04-0065-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Orthopedic Surgery which is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a lower back injury on 04/___/03 while lifting a block of cement. He complains of left-sided lower back pain and left buttock pain radiating down his leg. Per the orthopedic surgeon's notes, his lumbar MRI revealed a herniated nucleus pulposus at L4-5. He has undergone physical therapy and steroidal and non-steroidal anti-inflammatory medications with little relief in symptoms.

Requested Service(s)

Purchase of an RS4i 4-channel inferential and muscle stimulator unit

Decision

It is determined that the proposed purchase of an RS4i 4-channel inferential and muscle stimulator unit is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Based on the patient's history, diagnostic findings, related medical literature, and his medical diagnosis of chronic low back pain, there is no significant benefit that can be expected from the use of the RS4i stimulator. Therefore, it is determined that the proposed purchase of an RS4i 4-channel inferential and muscle stimulator unit is not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

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.

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 hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, 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 all other parties involved in this dispute.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

cc: Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 15th day of October, 2003.

Signature of IRO Employee:

Printed Name of IRO Employee: