

October 1, 2003

MDR Tracking #: M2-04-0021-01
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 Doctor of Chiropractic. 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

___ was working at a beverage company as a filler operator when he slipped in a puddle of oil, falling forward. He landed on his outstretched hands and had an immediate onset of pain in both wrists. He was referred by his supervisor to the company's doctor and was prescribed medication. He later began seeing ___ and was treated with physical medicine. MRI was also performed on the left wrist, which was largely negative. There was a CT performed on the "upper extremity", but it is not clear as to which extremity was examined. MRI of the right wrist was also largely negative. Records indicate that the patient was treated with aggressive physical medicine. EMG was positive for a mild carpal tunnel syndrome on the right and negative on the left.

REQUESTED SERVICE

The purchase of an interferential muscle stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ prescription presented indicates that the statement of medical necessity is to "increase muscle function" and "decrease pain". With regard to increasing muscle function, I do not find any research that indicates passive treatment will increase muscle function in and of itself. Rather, active rehabilitation is the most appropriate method of addressing such muscular imbalance. In this particular case, the patient was treated with extensive active rehabilitation to

include work hardening, from the records reviewed. If work hardening and active rehab were unable to make a difference in this patient's muscular imbalance, passive treatment is very unlikely to improve that condition. With reference to the pain control, this patient's last records indicate that the pain level was "2" out of "10". Another way of looking at this is that the patient was 80% without pain. This is likely very close to normal for any given individual and the ability of a muscle stimulator to improve upon that would be, at best, questionable. The records presented do not indicate the medical necessity of this DME and, in fact, generally prove the opposite. As a result, the reviewer finds there is not demonstrated medical necessity for the requested treatment.

___ 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 1st day of October 2003.