

October 1, 2003

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

MDR Tracking #: M2-04-0022-01  
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

\_\_\_ is a 32-year-old woman who sustained an injury while working for \_\_\_ on \_\_\_. She was using a buffer when she got slammed into a wall. She had pain to the neck, right shoulder and arm, and the low back. She also had aching pain in the hips and legs. She missed a few days of work and was subsequently doing light duty. She was seen in the emergency room and placed on Vicodin. Cervical and lumbar spine x-rays were done and they showed no acute changes. Her past medical history was significant for a previous L4/5 posterior decompression fusion with BAK cages and the cages appeared to be in good position with what appeared to be a solid fusion, with no lucency around the cages. She was treated with medications and physical therapy. The last note that was available for review is dated 7/11/03 and this note states that she continues with complaints of pain. Her examination remains basically the same. She was advised to stay as active as possible.

#### 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

It should be noted that \_\_\_ initially ordered a two-month rental of the RS-4i interferential and muscle stimulator. He then wrote a prescription for indefinite use on 7/16/03. He also wrote a letter dated 7/14/03 in which he states that the neuromuscular stimulator was prescribed on 5/27/03. He states that \_\_\_ rates the pain as high and as an eight some days, but states symptomatic relief provided by the device reduces her pain to a one and lasted for several hours. He stated that she has decreased her use of Lortab by 25% for pain control following a treatment and is sustaining this reduction. However, \_\_\_ progress notes do not mention the use of the RS-4i. Furthermore, his notes indicate that she continues to be very symptomatic. His letters note that the device is being used for her complaints to the cervical spine. However, the cervical spine x-rays done on 1/12/03 show that it was a normal study. Furthermore the MRI scan of the cervical spine done on 3/18/03 was normal.

Therefore, \_\_\_ notes do not show any improvement with the RS-4i muscle stimulator, despite his letter stating that it does. He does not mention the use of the device in his progress notes. If the unit is being used for the pain to the cervical spine, the cervical spine x-rays and MRI scan are normal. In addition, for the complaints to the lumbar spine, \_\_\_. notes that \_\_\_ had a previous L4/5 posterior decompression and fusion with BAK cages and the cages appear to be in good position with what appears to be a solid fusion and no lucency around the cages.

The \_\_\_ reviewer agrees with \_\_\_ 7/24/03 report. For her injury, her complaints appear to be out of proportion to the objective findings. Furthermore, the literature does not show any good objective double blind, peer reviewed scientific studies that prove the efficacy of the device.

Even though there is a study published in The Journal of Pain, Vol. 2, No. 5 (October), 2001: pp295-300, 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 appears 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.

The reviewer's decision is that there is no documentation of the medical necessity for 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 2<sup>nd</sup> day of September 2003.**