

October 9, 2003

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

MDR Tracking #: M2-04-0031-01  
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 31-year-old female who sustained a work injury on \_\_\_ when she slipped on some water while cleaning. She fell and "twisted." While she was falling, she somehow managed to catch herself on a basket and subsequently injured her back. She began with complaints of back pain that radiated to both lower extremities, more to the right than to the left. The pain radiated to the posterior aspect of her legs and radiated laterally to the outside of her thigh and to her toes with numbness and tingling to both feet. There was no burning. However, there was apparently some loss of bladder continence since the injury. The pain was also noted to radiate to the side of her foot and the bottom of her foot. With regards to her low back, the pain radiated from the low back all across, more so than to the left. She had more back pain than leg pain. The MRI scan of the lumbar spine showed mild canal and foraminal stenosis at L5/S1 secondary to disc bulging and facet joint hypertrophy. There appeared to be a small annular tear at the L5/S1 without evidence of frank disc herniation. She appears to have been treated with medications, physical therapy, and also underwent a lumbar epidural steroid injection. She also underwent epidurograms. She had strength and range of motion testing and also underwent a Physical Work Performance Evaluation.

Of note is that \_\_\_ wrote a prescription on 5/9/03 for two months trial of an interferential and muscle stimulator. He then wrote a letter for long-term use on 7/7/03.

#### 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

Review of the daily patient records from physical therapy show that the pain level on 10/14/02 was 9 on a scale of 0 to 10. On the last note of 9/11/03, nearly one year later, the pain level was also a 9.

\_\_\_ wrote a letter on 7/7/03 stating that \_\_\_ was improving with the use of the muscle stimulator. However, his note of 7/7/03 shows that the medication was not taking care of her pain like it should. He changed her to OxyContin. On that visit he recommended a discogram at the L4/5 and L5/S1 levels, as well as facet injections to help the arthropathy. Therefore, based on the medical records available for review, the interferential and muscle stimulator did not help this patient with her pain and did not do much in decreasing the use of the medications.

\_\_\_ 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 9th day of October 2003.**