

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 24, 2003

RE: MDR Tracking #: M2-04-0054-01
IRO Certificate #: 5242

_____ 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 _____ 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, 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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery who has an ADL Level 1. The Orthopedic Surgeon 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 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

The claimant was injured on ___ laying objects in a container 6 feet high and fell injuring his left and right hand and wrist, neck and low back. A cervical MRI was normal on 4/23/03. Lumbar MRI on 4/25/03 was read as disc bulge L2-L3 and L4-L5, disc protrusion L3-L4 and spinal stenosis at L3-L4. Treatment with analgesics, anti-inflammatories, muscle relaxants, Chiropractic, and physical therapy was not effective.

Requested Service(s)

RS4i sequential stimulator, 4 channel combination interferential and muscle stimulator unit..

Decision

I agree with the insurance carrier that above is not medically necessary.

Rationale/Basis for Decision

An extensive Medline search of the medical literature revealed no peer-reviewed scientific articles that support use of sequential stimulator muscle units for relief of low back pain or spasm. No articles were found in the literature referring to the use of sequential stimulators for this purpose. Without such documentation, medical necessity has not been established.

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.