

October 8, 2003

MDR Tracking #: M2-04-0064-01
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

___ sustained a work injury on ___. She was helping a patient transfer from the bedside commode to the wheelchair. She reached up and grabbed around the neck and then pulled her over. ___ sustained a twisting injury to the back and neck. She had low back pain immediately and neck pain started about two weeks later. She took off work.

The patient saw a doctor at the ___ and a nurse practitioner at the ___, but was told that because she had no insurance she should go to the ___. She saw ___ at the spine clinic who put her on a no lifting over five pounds restriction and recommended cervical and lumbar MRI scans. They were not done by the time she presented to the ___.

___ was given a prescription for a muscle stimulator. She also underwent epidural steroid injections, left sacroiliac joint block and epidurograms. Based on the records provided, the reviewer cannot determine whether or not she was given physical therapy.

The patient's diagnosis for this injury appeared to be cervical strain and lumbalgia with radiculopathy and disc bulge protrusion at the L4/5 and L5/S1 levels.

REQUESTED SERVICE

The purchase of an RS-4i interferential muscle stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

By review of the medical records, it appears that ___ did not get any relief with the treatment given. The last operative note of 9/15/03 shows that she is still having fluoroscopic needle localization of the left L4 and L5 neural foramina, epidurogram, and left L4 and left L5 transforaminal epidural steroid injection with subsequent segmental nerve root block. Based on the medical information available for review, it appears that this patient did not get any relief with the use of the interferential and muscle stimulator. Furthermore, the literature does not show any good objective, double-blind peer reviewed scientific studies that prove the efficacy of this 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, the study sample was small and the electrical stimulation appeared to have been discontinued after two months.

___ 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 ___, Inc, dba ___, 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 8th day of October, 2003.