

October 24, 2003

**NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter**

RE: MDR Tracking #: M2-04-0149-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old female who sustained a work related injury on ___. The patient reported that while at work she sustained an injury to her cervical spine while loading stage trusses. The diagnosis for this patient is cervicalgia. The patient has been treated with physical therapy, oral medications and an RS4i sequential muscle stimulator. The patient has undergone a anterior cervical discectomy and fusion with anterior cervical plating at the C4-5, C5-6 and C6-7 levels. The patient then underwent posterior cervical wiring using Atlas cable and posterior fusion at the C4-5, C5-6 and C6-7. The patient underwent diagnostics that indicated carpal tunnel syndrome as well as chronic left C7 radiculopathy and a mild left ulnar neuropathy disc protrusion at the C3-4 level and Z-joint changes posteriorly at the C7-T1 level. The patient has also been treated with cervical facet joint injections bilaterally with facet arthrography with fluoroscopic interpretation.

Requested Services

Purchase of an RS4i sequential stimulator 4 channel combination interferential & muscle stimulator unit.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 44 year-old female who sustained a work related injury to her cervical spine on ___. The ___ physician reviewer also noted that the diagnosis for this patient is cervicgia. The ___ physician reviewer further noted that treatment for this patient's condition has included oral pain medications and an RS4i neuromuscular stimulator. The ___ physician reviewer indicated that the patient has also undergone anterior cervical discectomy and fusion with plating C5-C7 on 7/21/01 and on 12/10/01 the patient underwent a S1 inter-body fusion with cage and posterolateral fusion with cages with Steffee instrumentation. The ___ physician reviewer explained that there is no clinical evidence supporting the efficacy of the RS4i Interferential Stimulator. The ___ physician reviewer also explained that the RS4i Interferential Stimulator device has not been proven effective for treatment of this patient's condition. Therefore, the ___ physician consultant concluded that the requested purchase of an RS4i sequential stimulator 4 channel combination interferential & muscle stimulator unit is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this 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)** days of your receipt of this decision. (20 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)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 24th day of October 2003.