

October 22, 2003

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

MDR Tracking #: M2-04-0159-01  
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 Physical Medicine and Rehabilitation. 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 30-year-old woman who was injured on \_\_\_, \_\_\_ months prior to this review. Per the \_\_\_ medical report, the patient was injured lifting boxes that contained soda fountain replacement liquid when she had an onset of back pain without radicular component. She was diagnosed with lumbar strain, given some Skelaxin, prescribed therapy, placed on modified duty and asked to return in three days. \_\_\_ apparently started later seeing a chiropractor instead. The earliest clinical notes are dated July, reflecting basically a diagnosis of lumbar pain syndrome. However, noted in the records is a prescription for the stimulator written from the chiropractor's office on \_\_\_, six days after her injury. The patient did not appear to follow with \_\_\_.

\_\_\_ has had no related surgical procedures. There was a June MRI that reported some disc changes that do not appear to be severe.

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

There is not sufficient evidence in the medical literature demonstrating that this modality has a lasting (more than temporary) effect on chronic pain problems. The current reputable literature and the overall reported practice experiences in medicine continue to strongly suggest other alternate modalities can give equal/similar temporary pain amelioration.

In addition, the 7/24/03 letter from the HCP justifies the purchase request by stating the device would not “overly stress the postoperative area,” that it would “retard disuse atrophy,” and that it would “increase local blood circulation. None of these are salient issues now in this case. It was also stated that it would “enhance the healing process by shortening the length of rehabilitation and therapy.” If that were the actual benefit, there should not be any justifiable request for a permanent purchase of the device.

\_\_\_ 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 22<sup>nd</sup> day of October 2003.**