

NOTICE OF INDEPENDENT REVIEW DECISION

October 28, 2003

RE: MDR Tracking #: M2-04-0167-01
IRO Certificate #: IRO4326

___ 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 a ___ physician reviewer who is board certified in pain management/anesthesiology which is the same specialty as the treating physician. The ___ 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

This patient sustained an injury on ___ when she slipped on a waxed floor and fell. She reported pain to her low back, right hip, and right shoulder. MRIs done on her cervical spine, right shoulder, and lower back were all normal. She attended physical therapy and had steroid injections to her right shoulder and right trochanteric bursa areas without much relief. She started seeing the pain management specialist on 11/01/02.

Requested Service(s)

Purchase of an RS4i sequential 4-channel combination interferential and muscle stimulator unit

Decision

It is determined that the proposed purchase of an RS4i sequential 4-channel combination interferential and muscle stimulator unit is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had pain since ___. Prior to the use of the muscle stimulator unit, her pain was 8-9 out of 10; per the 05/20/03 office visit notes. A subsequent visit on 08/04/03 showed the pain to be 4-6 out of 10. This is a significant improvement. The patient report of 05/29/03 showed that the patient has had increased movement with the unit. She also reports reduced intensity of spasms.

According to the North American Spine Society guidelines Phase III:

Palliative care issues are reasonable treatment if:

1. Allow for maintenance of functional capacity
2. Allow for management of crisis situations (such as ER visits)
3. Allows for successful management of symptoms
4. Allows for higher level of performance of activities of daily living.

(Unremitting low back pain. In: North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists. North American Spine Society. Unremitting low back pain. North American Spine Society (NASS); 2000. 61p,3(a) and (b)).

This patient has responded to the interferential and muscle stimulator unit with decreased pain and increased function. Therefore, it is determined that the proposed purchase of an RS4i sequential 4-channel combination interferential and muscle stimulator unit is medically necessary.

This decision by the IRO 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) 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 hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, 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 all other parties involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (h), 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 28 th day of October 2003.
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