

October 22, 2003

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

MDR Tracking #: M2-04-0170-01
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 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

___ was involved in a motor vehicle accident while working with ___. She presented to the emergency room at ___ where she was seen by the emergency room physician. She had cervical x-rays and a CT scan that showed degenerative changes but no fracture. She was referred to ___ who treated her with medications, physical therapy and an interferential and muscle stimulator. She had appropriate x-rays.

Physical therapy was of benefit and she was released to return to work. She was seen by ___ on 5/13/03, at which time he stated that she had reached MMI. He gave her five percent (5%) whole person impairment from the injury.

REQUESTED SERVICE

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

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The note of 9/30/02 shows that the cervical spine flexion and extension views showed anterior spondylosis at C6/7, although the CT scan of the cervical spine was unremarkable except for mild

degenerative changes. On this visit, he referred her to physical therapy. In the note of 11/19/02, he states there had been significant improvement of the cervicogenic pain with a course of physical therapy, medications and time. In the note of 12/18/02, he stated that the neck and low back pain had improved much with a course of physical therapy. On that note, he also stated significant improvement of the cervicogenic and low back pain with a course of physical therapy, medications and time. He also stated that she is ready to return to duty after New Year's. Despite this, he ordered a muscle stimulator for home use for pain and deconditioning. The note of 3/25/03 shows that ___ returned with significant worsening of the low back pain, despite the use of the muscle stimulator on a daily basis.

Therefore, based on ___ notes, this patient had significant improvement with physical therapy, medications and time.

Furthermore, there are no significant studies to indicate significant improvement in function or decreased utilization of medications associated with the use of an interferential and muscle stimulator.

___ 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 22nd day of October 2003.