

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 27, 2003

RE: MDR Tracking #: M2-04-0176-01
IRO Certificate #: 5242

___ 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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery and has an ADL Level 2. The Orthopedic Surgeon 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

The claimant has a history of chronic back pain allegedly related to a work injury on ___.

Requested Service(s)

Purchase of a interferential and muscle stimulator unit.

Decision

I agree with the insurance carrier that the requested durable medical equipment is not medically necessary.

Rationale/Basis for Decision

Generally long term use of stimulator is appropriate when there has been at least a two month trial to determine effectiveness and significantly increasing objective parameters such as increased range of motion, decreased use of pain medication, increase in functional activity, and a decrease in the need for other use of medical services. Prior to initiating the use of the stimulator the physician should document current range of motion, current use of pain medication and current activities the injured worker is able to perform. Prior to any extension of use, these objective factors should be measured again. Furthermore, there should be an explanation as to why long term use is needed. Upon review of all documentation provided, there is no evidence of a clinical trial indicating the effectiveness of the requested durable medical equipment. Most pain syndromes diminish over a period of four months and long term use is neither cost effective nor necessary. There is no documentation of exhaustion of

conservative measures including bracing and a well-structured home exercise program with instruction in McKenzie type spinal stabilization.

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 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.