

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0177-01
IRO Certificate Number: 5259

November 7, 2003

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

____ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ____.

CLINICAL HISTORY

This injured worker sustained a significant right upper extremity injury resulting in a number of fractures, surgical procedures and contractures to the digits, wrist and elbow. This was emergently surgically treated. Subsequent, there were complications requiring skin grafting, contracture release and other bony, plastic and restorative procedures. Chiropractic rehabilitation was undertaken. Between May 29, 2003 and July 15, 2003 the requested device was in use. The patient progress report noted no diminution of the use of pain medication.

REQUESTED SERVICE(S)

Purchase RS4i Stimulator.

DECISION

Endorse pre-authorization determination. (Deny)

RATIONALE/BASIS FOR DECISION

This is a complex injury requiring specific occupational and physical therapy to rehabilitate. This claimant needs motion and not electrical stimulation. The self assessment noted no decrease in the medication usage, no decrease in the amount of muscle spasm identified, an increase in the reported sleep interference and frequency in pain. In addition, the primary treating physician failed to produce any competent, objective, and independently confirmable medical evidence demonstrating the efficacy of this device. The only note are vendor driven boilerplate documents not on letterhead and signature stamped. Lastly, this is a passive device and noting the date of injury, this claimant should be doing only those active modalities that enhance the rehabilitation of this injury.

The proposed device is not broadly accepted as the prevailing standard of care and is not recommended as medically necessary. The Philadelphia Panel Physical Therapy Study found little or no supporting evidence to include such modalities in the treatment of chronic pain greater than 6 weeks. Moreover, the efficacy of this type of device in the long-term patient has been studied repeatedly. As noted by Herman (Spine 1994 Mar 1;19 (5):561) this treatment adds no apparent benefit. Further as described by Deyo (NEJM 1990 Jun 7(23):127-34) TENS is no more effective than placebo. The literature of blinded peer-reviewed studies does not support the efficacy of this device. The one study that was completed had a drop out rate of more than 50%, the appropriate methodologies were not reported and the overall efficacy was not a function of the device rather other external factors.

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 (20 Tex. Admin. Code 142.5©).

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 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a 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

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

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 10th day of November, 2003.