

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0187-01
IRO Certificate Number: 5259

October 20, 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 is a gentleman with a ten month history of a lumbar strain. This was treated conservatively with non-steroidal anti-inflammatory medications. Initial physical examination did not demonstrate any nerve root signs or neurological losses. Physical therapy was added to the treatment protocol. Complaints of back pain continued and MRI imaging study was normal. On March 14, 2003 he was released from care by ___. Care was transferred to ___ and an extraordinary amount of additional physical therapy was delivered. By September 5, 2003 maximum medical improvement was ascertained and a 5% whole person impairment rating assigned. He was cleared to return to work.

That was the last progress notes. There are two boilerplate notes from the vendor indicating that there is a requirement for the device requested. There is a report noting the efficacy of the device and in one month's time there was no change in the perceived success of the device.

REQUESTED SERVICE(S)

Purchase of a RS4i stimulator

DECISION

Endorse determination of pre-authorization providers (Deny purchase).

RATIONALE/BASIS FOR DECISION

The primary treating physician failed to produce any competent, objective, and independently confirmable medical evidence demonstrating the efficacy of this device. Moreover, in the progress notes of the provider (on his letterhead) there is no mention of the use or success of this device. The utilization curve is not documented and there is no measurable improvement in this condition. Has the use of oral analgesic been reduced? There is no data to indicate that is the case. Clearly there is no established positive result from this use of this device. The complaints of pain are essentially the same. Moreover, there is no clinical assessment made by the primary treating physician that would support the use let alone the purchase of this device. 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. Such passive modalities are indicated in the acute phase of care and their use must be time-limited. 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. Additionally, 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. Lastly 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. This device does not improve the situation, there is no

identification of a decrease in medication use and the functionality of the claimant was not reported out.

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 21st day of October, 2003.