

November 4, 2003
Amended November 10, 2003

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

MDR Tracking #: M2-04-0197-01
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 and board certification in Orthopedic Surgery. 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

___ is a 44-year-old woman who injured her right elbow and left thumb on ___. She was seen by ___ and was diagnosed with light elbow tendonitis, left wrist tendonitis and left trigger thumb. The patient was treated by conservative methods but failed to resolve her left trigger thumb.

She was seen by ___ and eventually underwent a left trigger thumb release on April 29, 2003. Post-operatively she was seen at ___ for physical medicine.

This patient has used a RS-4i stimulator to provide pain relief into her tennis elbow and left wrist.

As of August 8, 2003, ___ stated that the patient's final diagnosis included chronic tendonitis of the right elbow, left wrist and left thumb with status post left trigger thumb release on April 29, 2003. It was noted that the patient had "now completed her recovery and rehabilitation program after surgery." It was stated that the patient was "able to return to her regular work activities." It also stated that she has had "some minor residual aches

and pains to the elbow and the hand/thumb.” It states the patient may require some anti-inflammatory medicines or topical cream.

It is noted that this patient did undergo a RME on August 25, 2003 by _____. It states that the patient has reached MMI and has a 4% whole person impairment.

There is a letter of medical necessity dated July 9, 2003 from _____ regarding the requested DME.

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

Based on the medical records provided, the reviewer finds that the RS-4i stimulator is not medically necessary for this patient’s treatment. It is noted that this patient has clinical evidence of an acquired trigger thumb on the left which has been treated with appropriate surgery on April 29, 2003. She also has “aches” in her right elbow and left wrist consistent with mild chronic tendonitis/tendonopathy. The patient is functioning at a normal level. It would be inappropriate to recommend this device for her mild condition. Also, please note that there are no long-term studies to support the use of an interferential muscle stimulator on a regular basis for this condition.

_____ 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 10th day of November 2003.