

December 15, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0218-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 39 year-old female who sustained a work related injury on ___. The patient reported that while at work she tripped and fell injuring her neck and back. On 5/11/00 the patient underwent lumbar surgery in the form of ALIF at L5-S1. She also underwent carpal tunnel release on the left on 11/1/99, ACF C4-C7 on 1/26/02 and a re-do posterior surgery at L5-S1 on 5/18/02. An MRI dated 1/18/03 showed minimal disc bulge at C3-C4 with partial fusion at C4-C5 and a complete fusion at C5-C6 with a small bulge at C6-C7, with mild neuroforaminal narrowing on the right. The patient also underwent a lumbar spine series on 1/18/03. On 11/12/03 the patient underwent cervical spine and lumbar spine series. On 10/16/03 the patient underwent electrodiagnostic studies. The current diagnoses for this patient has included right leg atrophy and right foot drop. Treatment for this patient's condition has included lumbar surgery, injections and oral medications.

Requested Services

Purchase of an RS4i sequential stimulator 4 channel combination interferential & muscle stimulator unit.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 39 year-old female who sustained a work related injury to her neck and back on ____. The ___ physician reviewer also noted that the diagnoses for this patient have included right leg atrophy and right foot drop. The ___ physician reviewer further noted that treatment for this patient's condition has included lumbar surgery, injections and oral medications. The ___ physician reviewer explained that there is no established efficacy or proven benefit for the interferential muscle stimulator. Therefore, the ___ physician consultant concluded that the requested purchase of an RS4i Sequential Stimulator 4 channel combination interferential & muscle stimulator unit is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

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)** days of your receipt of this decision. (20 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)** 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. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

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 15th day of December 2003.