

November 18, 2003

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

MDR Tracking #: M2-04-0289-01
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 Physical Medicine and Rehabilitation. 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

___, a flight attendant, was approximately 53 years of age when she sustained a significant fall on ___ during turbulence on a flight. She had been in the process of working with a heavy food cart. When the cart moved with the turbulence, she sustained a fractured wrist and a severe right ankle injury that later required tendon repair surgery. This patient has also had problems of pain in the leg, neck, shoulder, and some persistent pain in the left low back, sacroiliac/hip area. She has had physical therapy, medications, treatments, and exercises.

In December 2002 she was seen further by a pain management specialist and received two sacroiliac joint injections and also received some aquatic physical therapy. It was felt that she could basically resume most activities, though she was on a voluntary leave of absence for about three years total.

In June of 2003 a letter was written to justify the purchase of a stimulator.

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

This item had been rented originally, and the letter of justification for this purchase had included such things as “increasing local blood circulation to increase the healing rate of the soft tissue injury.” It also stated that the stimulator “is a healing process” to “get to the origin of the pain rather than blocking the pain.” These do not appear to be valid physiological criteria for an injury that occurred more than two years prior.

There is insufficient evidence in the medical literature demonstrating this modality having a lasting /more than temporary effect on chronic pain problems. The current literature and the overall reported practice experiences in clinical medicine continue to strongly suggest other alternative modalities and self treatment methods to give equal or similar temporary pain amelioration. The purchase of this unit is not justified in this case.

___ 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 18th day of November 2003.