

December 2, 2003

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TWCC Medical Dispute Resolution
MS-48
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MDR Tracking #: M2-04-0392-01
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

___ is a 46-year-old male who slipped in 40 pounds of grease. He felt a sudden severe pop in his low back and lost control of his upper body, falling head first into a drum of grease while he was working for ___. He had severe back and neck pain. Cervical spine studies identified on a 7/29/99 MRI were C3/4 disc degeneration with foraminal stenosis, C4/5 disc degeneration and lateral foraminal stenosis on C4/5. In August of '99, a lumbar MRI identified an L4/5 herniated disc with left L4 nerve root involvement. He underwent an IDET procedure at L5/S1 on 7/2/01 by ___. On 5/15/02 due to failure of prior treatments, he underwent L5/S1 foraminotomy, laminectomy and fusion with hardware. On an FCE dated, 7/29/03 he was classified as capable of sedentary physical activity with no physical demands for activities below the waist.

___ changed his medications to achieve better relief of pain. ___ provided therapies on a regular basis. There was an interruption in his treatment of approximately one year because he was in prison during that time. During the time in prison, he reported a lot of back, leg, neck and shoulder and arm pain as well as arm weakness and numbness. After being released from prison, ___ was seen by ___ on 6/16/03 and medications were reviewed and an EMG nerve conduction study of the cervical spine was recommended. An EMG dated 7/16/03 by ___ reported mild right carpal tunnel syndrome, moderate left carpal tunnel syndrome, moderate right cubital tunnel syndrome, moderate left cubital tunnel syndrome and bilateral C5/6 radiculopathy. An MRI of the lumbar spine dated 7/16/03 identified a solid bone fusion of the L5/S1 level and mild degenerative changes at L3/4, and moderate sized anterior end plate osteophytes were noted.

On July 25, 2003 ___ recommended temporary use of the RS-4i stimulator to help control ___ symptoms and decrease atrophy, re-educate the muscle and facilitate his rehab. On August 22, 2003 ___ requested that this device be provided on a permanent basis for ongoing use to control his pain and symptoms. A nerve block was performed on ___, but it did not give him extended relief from his ongoing pain. A peer review by ___ dated October 2, 2003 recommended against the use of DME or against providing permanent use of the RS-4i stimulator. Notice of denial of pre-authorization was issued by ___, stating that peer review by ___ with ___ discussed the needs and mutually decided against the use of the RS-4i interferential muscle stimulator on September 15, 2003. In addition, a letter dated September 3, 2003 noted that an orthopaedic peer reviewer similarly did not agree with the purchase of this device, finding it medically unnecessary.

REQUESTED SERVICE

The purchase of an FS-4i interferential muscle stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The use of the RS-4i interferential muscle stimulator is controversial. Treating doctors need to provide clinical information that would help substantiate the benefit of the temporary use of this device, i.e., decreased use of pain medicine or increase in function, etc. In this case, clinical benefit was not established in the documents provided.

___ 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 2nd day of December 2003.