

December 2, 2003

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

MDR Tracking #: M2-04-0396-01
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 Doctor of Chiropractic. 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

Records presented indicate that this patient was injured on his job while driving a truck for ___. He was rear-ended by another vehicle while stopped at a stoplight. Records indicate he went to ___ and received X-rays. He later received care from ___, a chiropractor in ___. ___ performed trigger point injections on him. Chiropractic was administered 3 times per week during his treatment program. Records also indicate that a MRI was performed, but results are not presented. A letter of medical necessity, dated August 26, 2003, from the treating doctor indicates that the patient is being treated for cervicalgia and that a neurostimulator is being prescribed to avoid pharmacotherapy. The patient was seen on a RME by ___ on September 26, 2003 and indicated symptom magnification was a factor in this case.

REQUESTED SERVICE

The carrier has prospectively denied the medical necessity of a RS4i sequential stimulator 4 channel combination interferential and muscle stimulator unit.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Records on this case do not indicate that the patient has anything more severe than a myofasciitis, or perhaps a sprain/strain. The treating doctor diagnosed cervicalgia, which is non-specific. The records do show the effect of the stimulator, but that is not in question. This device is well known and well researched and does what it is supposed to do. The question on this case is whether that such treatment is appropriate for a patient with a sprain/strain injury that is 5 months old. I see no indication in the records that the requested service is necessary to relieve this patient's pain. There is no indication from these records that this patient would reasonably be considered to have pain serious enough to require such treatment at this point in a sprain/strain type of treatment. No records were presented by the requestor to indicate that the pain was organic in nature. As a result, the reviewer finds the care not to be reasonable 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 2nd day of December 2003.