

January 2, 2004

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

MDR Tracking #: M2-04-0417-01
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 in occupational medicine. 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 41-year-old man who sustained a work-related injury on ___ while working for the ___. He sat down on a chair that was broken, fell backwards, hitting his neck and head on a wall and also hitting his low back on the floor. He began with pain to the low back with pain and paresthesias radiating down the posterolateral aspect of the right leg, mainly to the great toe, with dyesthesias as well. He was treated with medication and physical therapy. He also had an MRI scan of the lumbar spine done and underwent an IDET procedure at L3/4, L4/5 and L5/S1 levels on 8/27/03. He also had an evaluation by an orthopedic surgeon.

The last note of 10/4/03 shows that ___ continues on Xanax, 0.25 mg, q. 6 hours, Talwin, one table twice or three times a day, Parafon Forte-DSC, one q.i.d., Propoxyphene, two tablets every six hours, and Naprosyn, 500 mg. b.i.d. His pain level on that visit was a three on a scale of one to ten.

REQUESTED SERVICE

The purchase of an interferential and muscle stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

A review of the medical records shows that ___ reported some decrease in his pain while he was using the interferential and muscle stimulator. However, his injury is also approximately fifteen months old and some decrease in pain would be expected during that interval. Furthermore, he required surgical intervention that appears to have helped him with some of his pain.

Also, records show the on the last visit for review which is dated 10/4/03, he is still on medications which include Talwin, Parafon Forte-DSC, Propoxyphene, Naprosyn and Xanax.

Therefore, based on the above, ___ medications have essentially not been changed due to the use of the interferential and muscle stimulator. Furthermore, some decrease in pain would be expected fifteen months after the injury and surgical intervention.

Furthermore, there are no peer reviews or scientific studies demonstrating either a short-term nor long-term efficacy of an interferential and muscle stimulator.

___ 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 January 2004.