

December 16, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0423-01

___ 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 by the American Board of Osteopathic Internal Medicine. 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 53 year-old male who sustained a work related injury on ___. The patient reported that while at work he was on a 13 foot ladder when he fell to the ground injuring his back. An EMG dated 7/18/03 indicated left S1 radiculopathy. An MRI dated 6/10/03 showed 4mm disc protrusion at L4-L5 and 1mm at L3-L4, lumbar facet arthropathy at L2-L3, L3-L4 and L4-L5 and broad-based disc bulge at L4-L5, L5-S1. A myelogram dated 10/6/03 showed broad based disc bulge at the L5-S1 level. The diagnoses for this patient have included mechanical low back pain with disc disruption, lumbar radiculopathy L4-L5 HNP, mechanical thoracic pain, contusion/possible fracture dislocation coccyx, degenerative disc disease L3-L4, L4-L5 and L5-S1 and S1 radiculopathy. Treatment for this patient's condition has included physical therapy and an interferential muscle stimulator.

Requested Services

Purchase of Muscle Stimulator.

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 53 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that the diagnoses for this patient included mechanical low back pain with disc disruption, lumbar radiculopathy,

L4-L5 HNP, mechanical thoracic pain, contusion/possible fracture dislocation coccyx, degenerative disc disease L3-L4, L4-L5 and L5-S1 and S1 radiculopathy. The ___ physician reviewer further noted that the treatment for this patient's condition has included physical therapy and an interferential muscle stimulator. The ___ physician reviewer explained that the interferential stimulator has not been proven efficacious. The ___ physician reviewer noted that the presence of muscle atrophy with an intact nerve supply is required for coverage by some forms of insurance, which consider coverage of these devices under specific criteria. The ___ physician reviewer also noted that the patient does not fit those requirements. The ___ physician reviewer further explained that the medical documents provided do not demonstrate that this treatment has benefited this patient. Therefore, the ___ physician consultant concluded that the requested purchase of a muscle stimulator 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 16th day of December 2003.