

NOTICE OF INDEPENDENT REVIEW DECISION

December 12, 2003

MDR Tracking #: M2-04-0430-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in pain management/anesthesiology which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This patient sustained a back injury on ___ when he was lifting a refrigerator. Treatment has included facet and epidural steroid injections, physical therapy, and anti-inflammatory and non-steroidal medications. A lumbar MRI performed 03/15/02 revealed disc bulging at L3-4 encroaching on the thecal sac.

Requested Services

The purchase of the RS4i sequential 4-channel combination interferential and muscle stimulator unit

Decision

It is determined that the purchase of the RS4i sequential 4-channel combination interferential and muscle stimulator unit is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical records provided on this patient do not show any improvement from the current stimulator use. There is no evidence that the stimulator has decreased the amount of pain medication, improved activities of daily living (ADL's), improved range of motion (ROM), or strength.

Under treatment goals on the prescription form, indications for use of the unit are to relieve acute pain, relax muscle spasms, prevent disuse atrophy, increase ROM and increase circulation. This patient does not have acute pain by definition. There is no evidence supplied showing that this has relaxed muscle spasms. There is no evidence the patient has a nerve injury or severe limitation of ROM as to produce disuse atrophy. There is no evidence that the unit has any effect on ROM. There is no indication that this patient has a problem with circulation. Therefore, the purchase of the RS4i sequential 4-channel combination interferential and muscle stimulator unit is not medically necessary to treat this patient's condition.

This decision by the IRO 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) 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 hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, 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 all other parties involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (h), 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 12 th day of December 2003.
