December 10, 2003
Amended December 31, 2003

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

MDR Tracking #: M2-04-0439-01
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 60-year-old woman who sustained a work injury on ___ at ___ while working at ___. She was scanning groceries when she picked up a 20-pound sack of potatoes. At that time, she felt immediate pain after her back "popped" to the mid thoracic region. She was placed in a wheelchair and was taken to ___where she was evaluated by ___ and diagnosed with thoracic strain. Further examination of the x-rays revealed multiple loss of space heights and compression fractures. She was treated with Medrol Dosepak, pain medications and muscle relaxants. She was also prescribed rest.

___ attempted to work four hours a day but stated that the pain improved little. She began with radiation of pain to the right lower extremity. A CT scan showed a T12 compression fracture. She also had degenerative changes involving L5/S1 bilaterally and mild degenerative changes at T7 and T8. Over a period of eight weeks of treatments as per ___ she noticed slow relief.

She was then evaluated and treated by ___. His treatment included medications, matrix bone healing protocol, lumbar facet blocks, nerve blocks, radiofrequency lesioning and implantation of a dual lead dorsal column stimulator. Which subsequently had to be removed because of infection. The interferential and muscle stimulator was ordered on 4/03/00. It also appears that ___ attended physical therapy, including work hardening. She had a FCE, and it was determined that she had reached MMI on 8/17/99, though she continued treatment thereafter.

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 show that this patient continued with complaints of significant pain despite all of the above treatment regimens, including insertion of a spinal cord stimulator. The last note that was available for review was from ___ and dated 10/28/03, showing that she continues with complaints of pain and is continuing on the medications, Neurontin, Flexeril, Darvocet-N 100, Bextra and Prozac. Therefore, based on the medial records available for review, it appears that the interferential and muscle stimulator did not affect ___ complaints of pain and did not change the medications, nor treatment that she was given.

Furthermore, there are no peer reviews nor scientific studies demonstrating either a short-term or long-term efficacy of the RS-4i 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.