

December 9, 2003

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TWCC Medical Dispute Resolution
MS-48
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Austin, TX 78744-1609

MDR Tracking #: M2-04-0447-01
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 and board certification in Orthopaedic Surgery. 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 46-year-old woman who injured her lower back when carrying a water jug on ___. She reported no leg weakness but had pain in the sacral region. She did undergo an MRI of the lumbar spine, which demonstrated a possible disc bulge/herniation at L5/S1. Plain x-rays demonstrated irregularity along the left S1 joint. An EMG/NCV study was negative. Lab work was negative for inkylosing spondylitis.

This patient underwent a left SI joint block with fluoroscopic guidance on July 29, 2003. This gave her about 25% pain relief. She had a complete physical examination, which was essentially unremarkable with the exception of mild tenderness over the left SI joint. She was seen by ___, a board certified psychiatrist who recommended the patient continue with weight loss and decrease mechanical stress. No further SI joint blocks were recommended. It was also recommended that the patient should continue with Flexoril as needed and should continue using her IFS unit. It was noted that the patient had reached

MMI on August 27, 2003 with a 1% whole person impairment based on the AMA Guides for the Evaluation of Permanent Impairment, Fourth Edition.

There is a letter of medical necessity in the chart that recommends the patient be treated with the purchase of an interferential muscle stimulator.

REQUESTED SERVICE

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

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient, a 46-year-old woman, sustained a lumbar strain/sprain and a left SI joint irritation/inflammation in a work-related injury on _____. Based on the treating physician, she had reached MMI. When she last visited the treating physician she had a normal examination with the exception of mild tenderness over the SI joint on the left side.

Based on the above narrative summary and the medical records reviewed, the reviewer finds that the purchase of an interferential muscle stimulator would be inappropriate for this patient. This statement is based on the fact that there is no orthopedic peer review literature, which would support ongoing interferential muscle stimulation for low back pain and SI joint inflammation secondary to low level trauma.

_____ 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 9th day of December 2003.