NOTICE OF INDEPENDENT REVIEW DECISION

Date: January 15, 2004

RE: MDR Tracking #: M2-04-0588-01
IRO Certificate #: 5242

___ 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 an Orthopedic Surgeon reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. 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
The claimant has a history of chronic low back pain allegedly related to a work compensable injury on or about ___.

Requested Service(s)
Purchase of RS4i sequential stimulator.

Decision
I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision
Generally, long term use of stimulators is appropriate when there has been at least a two month trial to determine effectiveness by objective parameters including but not limited to: range of motion, decrease in the use of pain medication, increase in functional capacity, and a decrease in the need for use of other medical services. Upon review of documentation provided, an ___ prescription dated 07/10/03 provides a Statement of Medical Necessity of improvement in function and a Treatment Plan includes maintaining or increasing range of motion and preventing or retarding disuse atrophy. There is no documentation of range of motion, functional capacity, extremity circumference, or other objective parameters prior to onset of use of the durable medical equipment or measurement of these objective parameters after use of the durable medical equipment to indicate any significant improvement with use over time.

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 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.