

NOTICE OF INDEPENDENT REVIEW DECISION

Date: January 12, 2004

RE: MDR Tracking #: M2-04-0596-01
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 back pain allegedly related to a compensable work injury on ___.

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 2 month clinical trial to determine effectiveness in significantly increasing range of motion, decreasing the use of pain medication and increasing functional capacity. Generally prior to initiating the use of the stimulator, the physician should document current range of motion, current use of pain medication, and current functional capacity. Prior to any extension of the use these objective factors should be re-measured. Upon review of ___ prescription dated 7/10/03 a statement of medical necessity includes the goal of improving function. The treatment plan includes maintenance or increase in range of motion and prevention or retardation of disuse atrophy. There is no documentation, however, of objective measurements of range of motion or functional capacity prior to initiation of use of the stimulator nor is there documentation of objective

measurement of these parameters after use of the stimulator to indicate any significant benefit from the use of the requested durable medical equipment.

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.