

January 23, 2004

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

MDR Tracking #: M2-04-0656-01
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

The patient sustained an injury in a slip and fall while at work on ___. She was evaluated by ___, an Orthopaedic surgeon for an RME on 3/11/03. It was opined at that time that the patient sustained a contusion to her knee and had developed chondromalacia to the patellofemoral joint, in addition to a lumbar strain, and recommended medication, bracing and restricted activity. ___ opined that the patient would not require any additional treatment to the left knee. A follow up RME from ___ dated 5/20/03 reported that the patient continued to have medial aspect pain with numbness. The patient was currently on no medication, and reported walking, standing and stair climbing made the pain worse. A physical examination revealed no patella sensitivity. ___ recommended medication, bracing, taping and strengthening exercises and stated she did not require surgery, and did not require additional chiropractics. A prescription for rental of an RS4 medical device submitted by ___, a chiropractor, was submitted 8/11/03 for treatment of left knee pain. The authorization denial opined that the medical necessity was not established for a purchase, noting that a passive muscle stimulator was not indicated for chronic condition and quoted AHCPD guidelines and referred to the Cochran's Collaboration regarding the lumbar spine. An MRI from 3/28/03 revealed no significant abnormalities of the knee, degraded by artifact from a needle embedded in the soft tissue behind the knee. Radiographs otherwise were within normal limits.

Medical Business Management Services summary dated 1/5/04 regarding the IRO request for pertinent medical information recapitulated the request was a purchase for an RS4 Interferential muscle stimulator, that the carrier denied compensable injury the back, right knee or leg, and that the patient only reported left knee and elbow injury. A prescription for indefinite use from ___ was noted, dated 10/24/03. It was opined that the patient noted a decreased in muscle spasm and pain and was sleeping better. A letter of necessity authored by ___ dated 10/23/03 discussed in typical boilerplate fashion the indications for an RS4 stimulator and the efficacy of this device. A clinic note from ___ dated 10/22/03 reported that since using this device there was a decrease of pain and spasms and that the patient was sleeping better, but maintained pain to her left knee, but was showing some improvement.

REQUESTED SERVICE

The purchase of an RS-4i interferential and muscle stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The rationale and basis for this decision is that an Orthopaedic surgeon trained in the diagnosis and treatment of trauma and other conditions of the knee opined that the patient had some patellofemoral changes, did not require surgery, and did not require further chiropractic. The patient had become under the care of a chiropractor, and treatment from the chiropractic was not recapitulated. The prescription for rental, and prescription for purchase is supported by letters, but there is no submission of the smart card data that objectified this equipment and the compliance in reference to duration and frequency of using the stimulator.

In reference to evidenced-based medicine, particularly the Cochran's Collaboration and more recently the Philadelphia Panel, there is insufficient data that there is any real efficacy among any of the widely accepted interventions for treatment of knee pain. Other than a TENS unit for osteoarthritis, electrical stimulation demonstrated no clinical important benefits. In regard to patellofemoral pain the Philadelphia Panel has no evidence to make any recommendation, with the implication that the analysis would be of poor evidence to support all these interventions.

Based on the absence of the Smart Card data, the lack of efficacy in evidenced based medicine in general, and specifically the opinions of an evaluating Orthopaedic surgeon that no further treatment was necessary, the medical necessity in this independent review cannot be confirmed.

Although generalizations regarding treatment should not be used for blanket approval and/or denials, in determining the medical necessity for investment, particularly in the Worker's Compensation arena, it is reasonable to address the information submitted in regard to objective data and anecdotal experience. In this particular case crucial information was lacking to help verify the necessity of this purchase.

___ 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 23rd day of January 2004.