March 2, 2004

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

MDR Tracking #: M2-04-0838-01
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 board certified and specialized 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 62-year-old driver of an eighteen-wheeler who injured his lower back while working on ___. He developed pain and muscle spasm in the lower back that extended into his hips and legs. ___, an orthopedist, examined him and placed him on medication for muscle spasm and pain. He also had an MRI performed that demonstrated evidence of right-sided spondylosis at L3/4 with canal stenosis at the L3/4 level. Osteophyte formation was also noted at the L3/4 level. He had some degenerative changes in the other discs below this L3/4 level, but they were mild in comparison to the anatomic changes that were present at L3/4.

The patient was referred to ___ who attempted conservative non-surgical treatment on the patient's back problem. He was given epidural steroid injection which did not give him any real significant amount of relief.

He also had physical therapy and various medications that were for the suspected neuropathy. He tried Neurontin, which was not helpful. He failed to improve, despite all types of conservative treatment ___ has requested that the carrier purchase an RS-4i sequential stimulator for this patient. He is now awaiting the carrier's approval of surgery, a spinal fusion ___ has requested this purchase, however, in spite of the fact that he is going to have surgery in the very near future.

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 purchase of the RS-4i stimulator is not needed and is not necessary in this case. The patient is awaiting surgical treatment on his back. The record does not have sufficient documented evidence that ___ was able to decrease his pain medications through the use of this device, or that it objectively increased his range of motion or the healing of his lower back injury There is no credible evidence in the orthopedic literature that establishes the effectiveness of electrical stimulation for the treatment of back pain. The benefit from permanent use of this item has not been established, and this unit is not felt to be within the standard of care for back pain.

___ 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 2nd day of March 2004.