

April 12, 2004

MDR Tracking #: M2-04-0947-01

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 specialized in Occupational Medicine. 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

There is a dearth of good medical records to obtain a brief clinical history of this patient. However, the office visit note of 05/06/02 by \_\_\_ shows that this patient had some decrease in her leg pain after the injections, especially on the right. However, she felt that she was back to baseline. \_\_\_ felt she was getting a little benefit from the Ultracet, especially after she had increased her activities. The neuromuscular stimulator decreased her pain and resolved her muscle spasms. She tried Vioxx, although it increased her blood pressure and Naprosyn caused rectal bleeding. She has a history of ulcers and colitis.

The impression was chronic intractable pain secondary to lumbar degenerative disc disease with an L5/S1 herniation. She is status post a previous discectomy. Review of reports from \_\_\_ showed that she had lumbar transforaminal epidural steroid injections, epidurography and supervision of conscious sedation, epidurogram interpretation three times, and she also had lumbar epidural adhesiolysis and steroid injection. Based on the letter done by \_\_\_ on 12/30/03 she also had physical therapy.

#### REQUESTED SERVICE

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

#### DECISION

The reviewer agrees with the prior adverse determination.

### BASIS FOR THE DECISION

\_\_\_ medications, which include Hydrocodone/APAP and Ultracet continue to be the same. Furthermore, the last note by \_\_\_ on 10/23/03 shows that she may be a candidate for a spinal cord stimulator trial.

Therefore, the treatment mentioned above, especially that given by \_\_\_, appears not to have changed her pain. \_\_\_ stated that this patient may be a candidate for a spinal cord stimulator trial. Therefore, with no apparent improvement with the above treatment, an interferential and muscle stimulator is not indicated. It appears that this patient has chronic intractable low back pain that is not helped with medications or the surgical procedures that she had done.

There are no peer review or scientific studies demonstrating either a short-term or long-term efficacy of an interferential and muscle stimulator.

Based on the above information, the reviewer finds no rationale for the medical necessity of the proposed purchase of an interferential and muscle stimulator.

\_\_\_ 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 \_\_\_, Inc, dba \_\_\_, 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 12<sup>th</sup> day of April 2004.**