

April 2, 2004

MDR Tracking #: M2-04-0992-01

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 no information from the treating doctor that gives this patient's clinical history. The only information is a handwritten note for the interferential and muscle stimulator dated 01/08/04, which gives the diagnosis of neck pain.

___ IME report done on 12/11/03 shows that ___ was employed by ___ at the time of the injury on ___. She was injured when her foot slipped and she fell backwards while carrying some parts in her hands. She continued to work until December 2002, at which time she stopped working and has not worked since. She was apparently given permission to return to work with the limitation of lifting no more than 35 pounds, but she was apparently not accepted at work with the restrictions.

She initially saw the company doctor. She was then seen by ___ who treated her for low back problems and she apparently had injections. She chose to change doctors and changed to ___. She has had no surgery. She had physical therapy and states that injections to the right and lower side of the lumbar spine or back area by ___, and her left upper neck, were helpful. She apparently had an MRI scan of the lumbar spine and two MRI scans of the cervical spine. She also had a neurological consultation, but no surgery had been recommended.

REQUESTED SERVICE

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

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

There is no supporting medical documentation from the treating doctor showing that the purchase of the interferential and muscle stimulator unit is appropriate for this patient. Furthermore, there are no peer-reviewed or scientific studies demonstrating either the short-term or long-term efficacy of an interferential and muscle stimulator unit.

___ 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.

<p>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 April 2004.</p>
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