

April 8, 2004

MDR Tracking #: M2-04-0995-01

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 Orthopedic 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 45-year-old truck driver whose truck was hit from the rear by another truck on ___. Shortly after the accident, the patient complained of lower back pain. He said the pain was radiating up and down his back into both legs posteriorly. He was directed to the local emergency room where he saw the emergency room doctor and went then to the ___ and began seeing ___ and ___. He received physical therapy and was told that, since he weighed 340 pounds and was 5'5" tall he needed to lose some weight. An EMG on 11/12/03 demonstrated mild L5/S1 radiculopathy. He had an MRI that demonstrated some degenerative changes, but there was no real significant nerve root compression. ___ saw him on 10/01/03 and felt that he could return to work. He received physical therapy and did receive a RS-4i sequential muscle stimulator unit, which he used for about one month. He reported that this unit gave him some relief of pain, according to the handwritten progress note, and because this unit helped his pain, his treating physician requested that the insurance company purchase a unit for him so that he could use it all of the time. This request was not approved. ___ was released by ___ on 12/16/03 and was told that he could return to work, but he did not do so. He saw ___ and stated that he did not feel he could continue working. He then began to see ___ and ___. In regard to this case, it appears that this patient verbally reported to the doctor that the RS-4i sequential muscle stimulator made his back feel better.

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 medical records provided for review do not contain any documented proof that the unit in question gives any advantage toward healing, and there is no documented evidence that this unit is helpful in the treatment of a lumbar back strain. The ___ reviewer does not find that this unit should be purchased by the carrier.

___ 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 8th day of April 2004.</p>
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