

April 13, 2004

MDR Tracking #: M2-04-1047-01

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

In the medical information submitted for review there are no good progress notes for a clinical history. Most of the information submitted is from operative procedures. However, the diagnoses range from lumbar radiculopathy secondary to left posterolateral, discal protrusion at the L4/5 level, and herniated lumbar disc at the L3/4 and L4/5 levels.

She was treated with lumbar epidural steroid injection, fluoroscopically guided percutaneous laser discectomy, intradiscal injection of local anesthetic and steroid mixture, and intradiscal injection of antibiotic solution, IDET and discogram at the L2/3, L3/4, L4/5 and L5/S1 levels. She was also treated with medications. ___ report of 03/12/04 shows that she is no longer on any medications. She only has occasional flare-ups of her back pain. She has been trying to work as a substitute teacher. She does not need any medications at all. Follow-up will be on a PRN (as needed) basis.

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 reviewed, especially the report from ___ dated 03/12/04, show that ___ is no longer on any medications and that she has only occasional flare-ups of her back pain. She is also trying to work as a substitute teacher. She does not need any medications at all and she an return for follow-up on a PRN (as needed) basis.

Based on the above information, it appears that this patient has essentially resolved her complaints from the injury and therefore no interferential and muscle stimulator is needed.

Furthermore, there are no peer reviews or scientific studies demonstrating either a short- or long-term efficacy of an interferential and muscle stimulator unit.

Therefore, there is no rationale for the medical necessity of the proposed purchase of the requested 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 ___, 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 13th day of April 2004.