

May 24, 2004

Re: MDR #: M2-04-1131-01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

From Requestor: office notes, physical therapy notes, functional capacity evaluation.

From Respondent: letters of denial and correspondence.

Clinical History:

The claimant appears to have a chronic low back pain condition as a result of a work-related injury on ___, described as "lumbagon". Details of the injury were not readily apparent in any of the records provided. However, office note documentation appears to indicate that the patient had unsatisfactory relief of chronic pain with medications such as Ultracet and Skelaxin, and that he has suffered from side effects from these medications that caused him to refrain from taking them, resulting in less control of his back pain. He has also been treated with physical therapy and with short-acting narcotics such as Tylenol with codeine.

Disputed Services:

Purchase of muscle stimulator

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that purchase of a muscle stimulator is medically necessary in this case.

Rationale:

In reviewing the documentation provided, especially the request by the patient's physician, it appears that this patient has had unsatisfactory control of his pain with a

variety of treatment attempts including various medications, physical therapy, etc. Letters by treating doctor appear to indicate that this patient does have significant benefit in his symptoms from the use of the stimulator that has been requested, with an increase in function and decrease in pain reported. There is documentation indicating that the claimant's quality of life and daily activities of living are enhanced. If this is indeed is the case, and I see no reason to believe that it would not be, I am of the opinion that it would be reasonable and medically necessary to provide this stimulator unit for this claimant, which may ultimately help not only with better symptomatic control, and improved quality of life, but perhaps may also help to less utilize other medical resources such as continued physical therapy, medications such as short acting narcotics, and other medications that have caused side effects, etc.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©)

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3)

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on May 24, 2004.

Sincerely,