

May 6, 2004

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744-1609

MDR Tracking #: M2-04-1174-01  
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 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

\_\_\_ is a 29-year-old man who injured his lumbar spine while lifting a generator at work. He felt a "pop" to his back and developed severe pain. He presented to \_\_\_ emergency room and appears to have been treated by the emergency room physician. The assessment was acute lumbosacral back strain and spasm.

\_\_\_ was followed at \_\_\_, was treated with medication and returned to restricted duties. He was also started on physical therapy. It appears that he subsequently developed migraine headaches. He was evaluated by internal medicine and had electrodiagnostic studies done by \_\_\_, with the studies normal.

He was also evaluated by \_\_\_, who recommended medications and lumbar epidural steroid injections.

This patient was also evaluated by \_\_\_\_\_. He underwent psychological evaluation by \_\_\_\_\_ was treated by \_\_\_\_\_, and finally was treated by \_\_\_\_\_, \_\_\_\_\_. The progress note by \_\_\_\_\_, dated 01/21/04 shows that \_\_\_\_\_ had evaluation for MMI, and was given 0% whole person impairment. The note by \_\_\_\_\_ appears to show that he agrees with the MMI determination, although he stated that the impairment should have been 5% whole person impairment.

#### 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

There was no documentation of the medical necessity for the proposed purchase of the interferential and muscle stimulator unit. The records reviewed show that this patient did improve with the treatment he was given. He was able to reach MMI status. \_\_\_\_\_ note dated 01/21/04 shows that the MMI evaluation was done by \_\_\_\_\_ and that on that day of the impairment rating, \_\_\_\_\_ had no lumbar tightness, although \_\_\_\_\_ stated that he had noted lumbar tightness since the injury.

MMI is “the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.”

Since \_\_\_\_\_ reached MMI and was apparently having no tightness to the lumbar paraspinal musculature, and because there are no peer review or scientific studies demonstrating either the short- or long-term efficacy of an interferential and muscle stimulator unit, the reviewer finds no rationale for the medical necessity of the purchase of the RS-4i.

\_\_\_\_\_ 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.

**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 6<sup>th</sup> day of May 2004.**