

NOTICE OF INDEPENDENT REVIEW DECISION

May 12, 2004

MDR Tracking #: M2-04-1186-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in Physical Medicine & Rehab by the ___, licensed by the ___ in ___, and who provides health care to injured workers. This is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This patient sustained a work-related injury on ___ when an ATV 4 wheeler flipped and he fell, hitting his head, left forehead, and shoulder area. On 12/16/97, the patient underwent an anterior fusion/discectomy with plating at C4-5. On 08/25/98 he underwent lumbosacral back surgery and on 08/27/99 he had the area redone with the insertion of BAK cages and posterior instrumentation with a fusion of L4-S1. He underwent a 3rd surgery on 06/12/00 with hardware removal, posteriorly, with cages left in. It appears that the last back surgery was performed on 06/12/00 when he developed an abscess of the surgery site. In addition, the patient underwent an arthroscopic repair to his right rotator cuff repair. The patient is suffering from chronic pain and has had a Morphine pump for pain relief.

Requested Service(s)

Purchase of a R54i Sequential Stimulator 4 channel combination interferential and muscle unit.

Decision

It is determined that the purchase of a R54i Sequential Stimulator 4 channel combination interferential and muscle unit is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The R54i 4 channel Sequential Stimulator has been shown to benefit selected patients with chronic spinal pain. This patient has completed a successful trial of usage and will benefit for its use in the form of better pain control and reduction of medication usage. Therefore, the purchase of a R54i Sequential Stimulator 4 channel combination interferential and muscle unit is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this 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 hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, 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 all other parties involved in this dispute.

Sincerely,

| |
|--|
| In accordance with Commission Rule 102.4 (h), 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 this 12 th day of May 2004. |
|--|