

June 16, 2004

MDR Tracking #: M2-04-1217-01

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

This patient is a 34-year-old woman who injured her shoulder, arm and neck on ___ while working for ___. She was apparently lifting 30-pound bags of kitty litter when she originally injured her back. She was treated by ___ with a diagnosis of shoulder strain and then returned to work on 07/16/98 with a 0% impairment rating. However, the record indicates that she continued to complain of pain in different parts of her body and she had a multiplicity of subjective complaints throughout her entire body. She was then diagnosed as having post-traumatic fibromyalgia, primarily on the basis of her continuing subjective complaints.

Over the years, ___ has been treated with multiple medications, physical therapy and multiple modalities. The record indicates that she has also been treated by ___ and her chiropractor, ___. She has a variety of complaints throughout her body and she takes Skelaxin, Elavil and Zoloft, Lortab 5 mg, Sonata and Lexapro 20 mg on a daily basis. In addition, her chiropractor has requested the purchase of an RS-4i electrical stimulator for the muscles in her body, and this request has been denied by the carrier.

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 purchase of the RS-4i is not appropriate for treatment of this injury. There are insufficient explanations as to the benefits that are obtained from this muscle stimulator, and there is insufficient documented evidence that the patient will be able to gain any benefit from this device. There is no evidence in the orthopedic literature that establishes the effectiveness of electrical muscle stimulation for the treatment of fibromyalgia or other orthopedic conditions.

___ 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.

<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 16th day of June 2004.</p>
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