May 25, 2004

Re: Medical Dispute Resolution
MDR #: M2-04-1227-01
IRO Certificate No.: 5055

Dear ___

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ or 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 ___ 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/Neurology 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
Information from Requestor: office notes, physical therapy notes (11/06/03 – 03/27/04), operative report 03/11/04, MRI 08/26 & 08/28/03.
Pain Management clinical info: 12/03, 01/14, 02/17, 03/24/2004.
Orthopedic clinical info: 11/11/03 - 02/05/04.
Information from Respondent: letters of denial.

Clinical History:
The claimant sustained a work-related injury on ___. She had development of neck pain as well as low back pain. She has undergone various treatment attempts including physical therapy, various medication trials, cervical facet joint injections, lumbar facet joint treatment, and the use of a muscle stimulator unit, which has now been requested for indefinite use.

According to the claimant's own correspondence, dated 3/27/04, she has returned to work full duty mainly as a result of the pain relief offered by the stimulator unit, which has also allowed her to participate in daily activities, such as house cleaning, etc. She has been able to reduce usage of strong pain relievers such as short-acting narcotics such as Vicodin, as well as muscle relaxers that can be sedating, such as Flexeril, both of

which do not allow her to function at work because of side effects, etc. There is documentation that the claimant did benefit temporarily from the surgical facet joint injections, but that the symptoms did then return to troublesome levels a few months later, which were then reduced by the use of the stimulator unit.

Disputed Services:
Purchase of an R54i sequential stimulator 4-channel combination interferential & muscle stimulator unit.

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:
It is quite evident by the documentation provided both by the claimant as well as the physicians involved in her care that she has benefited greatly from the use of this stimulator unit. Not only has this allowed her to function at work and at home, and return to work full duty, but has allowed also for her to reduce medications that not only can cause physical dependence with continued regular use, but were clearly causing side effects that would not allow her to function as satisfactorily at work. Considering that the claimant has already undergone various other treatment trials, including facet joint injections, as well as physical therapy, it is both reasonable and medically necessary to have her continue with the use of the stimulator device.

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 25, 2004

Sincerely,