May 17,2004

David Martinez
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

MDR Tracking #: M2-04-1232-01
IRO #: 5284

___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.

This case was reviewed by a licensed medical doctor who is board certified in pain management. 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

___ has been diagnosed with a cervical herniated disc and thoracic sprain. An MRI performed on 9-3-2003 revealed multilevel degenerative disc disease which more significantly involves C6-C7 with a left lateral disc protrusion and left-sided neuroforaminal stenosis. Her back complaints are listed as intermittent. Her neck complaints are reported as intermittent with tingling in the left arm and hand and weakness in the left arm and hand. A diagram on an RS Medical prescription dated 10-30-2003 revealed the treatment area to include the right and left suprascapular, the right and left lower cervical and upper thoracic paraspinals muscles. The diagnosis on the RS medical prescription included:

1. Muscle spasms
2. Neck pain
3. Cervical herniated discs.

The statement of medical necessity intends to decrease pain, spasm and to restore muscle function.

The treatment history listed on the RS Medical prescription includes physical therapy and oral medications. ___ in a note on 1-28-2004 to Sedgwick, asked for authorization of the interferential neuromuscular stimulator stating that he is trying to treat her conservatively and not use long term narcotic medications. He also stated that ___ gets good relief with the stimulator from her chronic pain. RS Medical, in its patient usage report, reported multiple modalities of benefit to the patient.

REQUESTED SERVICE

The disputed service is the prospective medical necessity of the purchase of an interferential muscle stimulator.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

___ reports intermittent muscle spasm which has not been quantified as to the frequency to justify the request of the RS Medical device. The patient dos not have wide areas of muscle spasms which cannot be covered by a simple TENS unit. The reviewer indicates his opinion is based on acceptable standards of practice which are recommended by multiple medical specialty societies.

___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 this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) 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 Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

Sincerely,

**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 17th day of May 2004**