

July 28, 2004

MDR Tracking #: M2-04-1306-01  
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

\_\_\_, a 52-year-old woman, had an injury on the job on \_\_\_. The details of this injury are not given. She has been having severe pain in her neck with radiation into the right shoulder and down the right upper arm since March 2004. She also has complained of numbness and tingling and some degree of weakness in her right arm. These symptoms have been suggestive of cervical radiculitis. She had an MRI on January 12, 2004 and her MRI demonstrated degenerative joint disease, particularly noted in the C5/6 joint with narrowing of the joint and degeneration of the disc. There was a paracentral disc herniation at that level with some pressure on the left side of the nerve root, however, her pain is reportedly on the right side. There was also mild narrowing of the spinal canal at C4/5 due to degenerative changes.

The patient is apparently being treated at this time by \_\_\_, who requested that the insurance carrier purchase an RS-4i sequential four channel combination interferential and muscle stimulator for this woman. He states that she has used this item and it has given her relief of symptoms.

#### 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

With regards to this case, there is no credible evidence in the orthopedic literature that establishes the effectiveness of electrical stimulation for the treatment of neck pain and radicular pain. There is do documentation submitted that indicates that the injured worker has been able to use less pain medication or regain motion while she has been using the unit. Permanent use of an electrostimulator has not been established to be beneficial, and there is no information from the treating physician that documents an improvement in this patient's condition based on objective findings.

The \_\_\_ reviewer agrees with the insurance carrier that the purchase of the RS-4i is neither reasonable nor necessary for this woman's treatment. The benefit for permanent use of this unit has not been established and this unit is not within the standard of care for neck pain and radicular pain.

\_\_\_ 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.

**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 29<sup>th</sup> day of July, 2004.**