

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** May 27, 2004

**RE: MDR Tracking #:** M2-04-1336-01

**IRO Certificate #:** 5242

\_\_\_ 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 an Orthopedic Surgeon reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. 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**

The work injury occurred on \_\_\_ while employed by \_\_\_. The claimant was lifting entertainment center and other person lost grip. Conservative treatment initially. Complaints of left low back pain with left radiculopathy. Neurologic exam on 8-23-01 by \_\_\_ was normal. MRI on 7-23-01 showed a small disc protrusion at L5. Pt underwent lumbar laminectomy and discectomy at L5 with S1 nerve root decompression on 8-29-01. Her surgery was unsuccessful. She has continued with left low back and left lower extremity pain complaints.

### **Requested Service(s)**

RS4i stimulator.

### **Decision**

I agree with the insurance carrier that above is not medically necessary.

### **Rationale/Basis for Decision**

There is no evidence in the peer reviewed medical literature that establishes objective evidence that the above device is effective. Since evidence is nonexistent, the only way to evaluate this device would be a 60 day trial on an individual basis. Evaluation should be based on reduction in analgesics, objective evidence of increased physical activity, and return to work. The ideal evaluation should be by a qualified physician who is unaware of her original condition at the time the stimulator was initially applied. Without quantifiable objective evidence as recommended above. The device could not be approved as medically necessary.

## 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 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.