

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 4, 2004

RE: MDR Tracking #: M2-04-1352-01
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 a Plastic/Hand Surgeon reviewer (who is board certified in Plastic Surgery/Hand and Upper Extremity 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 patient is a 49 year old female who was injured on ___ when working as director for a group home for mentally challenged children. She sustained a human bite to the left arm. She has been followed by ___ who has treated her conservatively. An MRI obtained on 12/11/03 revealed a small amount of fluid in all three wrist compartments consistent with mild synovitis, soft tissue swelling being more evident about the medial aspect which is consistent with soft tissue injury and mild extensive tenosynovitis. An incidental note was made of a small bone island in the lunate. A diagnosis was made of blunt finger to the left radial nerve and left lateral antecubital cutaneous nerves. Specific services required pre-authorization of an RS-4i muscle stimulator related to the ___ injury.

Requested Service(s)

Purchase of RS-4i interferential muscle stimulator from RS Medical ordered by ___.

Decision

I agree with the insurance carrier that the RS-4i muscle stimulator pertaining to the ___ injury as not being proven efficacious in this particular condition.

Rationale/Basis for Decision

Specifically, Section 413.14 (A) of the Texas Labor Code clearly states that investigation or experimental service or device means of health care treatment service or device for which there is an early developing scientific or clinical evidence demonstrating a potential efficacy of treatment, service or device but that is not yet properly accepted as the prevailing standard of care. In addition, the literature support for the use of this device and the specific treatment of “blunt injury to the radial nerve and antecubital nerve. In addition, there is no documented proof that indeed the patient sustained injury to the nerve indicator.

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.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 30th day of June 2004.