

July 26, 2004

MDR Tracking #: M2-04-1408-01  
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 specialized in Occupational Medicine. 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

The only information on the clinical history is a letter written by the patient, \_\_\_, and addressed to \_\_\_. He states that he injured his lower back over four years ago, that the injury was severe and he has been in an aggressive pain management program for two years to correct his injury. He was treated with medications, a TENS unit, and an interferential and muscle stimulator. He states that he has been in vocational training through \_\_\_ for the past 18 months.

The diagnoses given on the reports from \_\_\_ are lumbar radiculitis and status post lumbar laminectomy.

#### 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

To begin with, \_\_\_ injury appears to have occurred over four years ago, with \_\_\_ stating on the letter of \_\_\_ that he injured his lower back over four years ago. He underwent surgery to correct the injury. The diagnosis given in the records from \_\_\_ is lumbar radiculitis and status post lumbar laminectomy. Review of the records from \_\_\_ dated 03/23/04 and 04/19/04 show the

physical examination to show only mild tenderness over the paralumbar spine, right and left, at the L3/4 through L5/S1 levels. Therefore, based on the minimal records available for review, it appears that the findings on the physical examination are not significant.

Though there is a study published in The Journal of Pain, Vol. 2, No. 5 (October), 2001: pp295-300, entitled Electrical Muscle Stimulation as Adjunct to Exercise Therapy in the Treatment of Non-acute Low Back Pain, A Randomized Trial, the study sample was small, and the electrical stimulation appeared to have been discontinued after two months.

Furthermore, there are no scientific studies to indicate significant improvement in function or decreased utilization and medication associated with the use of an interferential and muscle stimulator.

The \_\_\_ reviewer also agrees with the comments on the letter dated 04/15/04 from \_\_\_ noting that such passive modalities are indicated in the acute phase of care and their use must be time-limited.

Therefore, based on the above, there is no documentation for the medical necessity of the proposed purchase of the RS-4i interferential and muscle stimulator.

\_\_\_ 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 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 26<sup>th</sup> day of July, 2004.**