July 13, 2004

REVISED REPORT
Corrected date of injury in clinical history.

Re: Medical Dispute Resolution
MDR #: M2-04-1420-01
IRO Certificate #: 5055

Dear ___

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Neurology and in Pain Management and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: History & physical exam, physical therapy notes and radiology report.
Information provided by Respondent: correspondence.

Clinical History:
The claimant sustained an injury on the job on ___ that resulted in some pain in the ankle as well as lower back. The claimant has been seen by a pain management specialist who has documented that the claimant has benefited from the routine use of the muscle stimulator unit. In fact, he notes that this device has resulted not only in decreased pain levels and muscle spasms, but has allowed the claimant to reduce his level of outpatient therapy as well as certain medication usage and costs, etc. Several progress notes indicate that the claimant is reporting benefit from the use of this unit, allowing for better function in addition to lessening pain.

Disputed Services:
Purchase of an RS4i sequential stimulator 4-channel combination interferential and muscle stimulator unit.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that purchase of the RS4i muscle stimulator unit as stated above is medically necessary in this case.

Rationale:
It appears well documented in the records provided that the claimant has benefited with the continued use of the muscle stimulator unit, which has allowed for not only a reduction in the pain, but has enhanced functioning for this claimant, with a concomitant decrease in other treatment modalities including medications, outpatient therapy, etc. On this basis, it is reasonable for this claimant to make use of the stimulator unit indefinitely, as it is certainly possible that the pain condition that resulted from the work-related injury is chronic and muscle pain symptoms may continue to be present indefinitely.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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 Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.
I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on July 13, 2004.