

June 24, 2004

MDR Tracking #: M2-04-1422-01

IRO #: 5284

___ 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.

This case was reviewed by a licensed Medical Doctor who is board certified in Anesthesiology and Pain Management. 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

___ is a 48 year old male who sustained a "twisting type injury" to his neck. Physical examination as documented by the physician on 1-07-2004 does not document any focal neurologic deficit, no tenderness or any spasms. The physical therapist administered several treatments with iontophoresis of steroids and cervical traction. Ultrasound therapy was also administered. The physician documents a mild spasm of the neck on 2-16-2004. ___ also underwent a comprehensive evaluation at the ___ on 4-26-2004 which documented cervical sprain and decreased range of motion of the neck.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of the purchase of a RS41 sequential 4 channel combination interferential and muscle stimulator.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer states that although interferential therapy is used widely in the physiotherapy and rehabilitative medicine settings, there is a dearth of rigorously controlled studies to justify its effectiveness in the management of either acute or chronic pain syndromes. Of interest, two recently published randomized, controlled trials involving interferential therapy failed to demonstrate any additional analgesic effect compared to traditional (conservative) management of shoulder (1) and back (2) pain.

1 Van der Heijden et al, No effect of bipolar interferential electrotherapy and pulsed ultrasound for soft tissue shoulder disorders. A randomized controlled trial. *Ann Rheum Dis* 1999; 58; 530-40.

2 Werners R, et al, Randomized trial comparing interferential therapy with motorized lumbar traction and massage in the management of low back pain in a primary care setting. *Spine* 1999; 24: 1579-84.

___ 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.

Sincerely,

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.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) 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 Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

Sincerely,

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 25th day of June 2004.