

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** July 16, 2004

**RE: MDR Tracking #:** M2-04-1453-01  
**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 Anesthesiologist and Pain Medicine reviewer (who is board certified in Anesthesiology/Pain Medicine) 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.

### **Submitted by Requester:**

- \_\_\_ prescriptions
- Computer generated form letters, signed by the provider
- Assessment of impact of stimulator, with minimal decrease in pain (7-8 to 7-7)
- Usage reports, provided by \_\_\_

### **Submitted by Respondent:**

- No clinical documentation included

### **Clinical History**

49 year old female with back pain and spasm. Has used the RS muscle stimulator since 1/23/04.

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

Review the medical necessity for an RS4i sequential stimulator 4 channel combination interferential and muscle stimulator unit, are within my scope of practice.

**Decision**

Agree with prior reviewers that the device is not medically necessary.

**Rationale/Basis for Decision**

The patient has not had quantifiable improvement in her functional status, activity levels, use of medications, or any significant improvement in symptoms to justify long term use of this device. A reduction in VAS score from 7-8 to 6-7 is not significant, nor is “a little better” a quantifiable measurement, nor a statement of any long-term advantage. No evidence-based clinical studies have ever demonstrated efficacy of these devices for chronic conditions.

**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 16th day of July 2004.