

July 12, 2004

MDR Tracking #: M2-04-1482-01  
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 board certified and specialized in Orthopedic Surgery. 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

\_\_\_ is a 49-year-old woman who was working for \_\_\_ when she injured her lower back while repeatedly lifting VCR units. She noted pain in her low back that began to cause considerable muscle spasm in her back. She went to the emergency room where she was seen, treated and released. She was then referred to \_\_\_ who treated her for a short time with medication and some physical therapy. She was declared to be at MMI by \_\_\_ on 11/08/02 and given a 0% impairment rating.

She continued treatment with \_\_\_, an orthopedic surgeon. \_\_\_ did an MRI on her back and found only some mild annular bulging and findings compatible with age but no herniated disc or evidence of nerve root compression. The patient had a series of three epidural steroid injections and was given physical therapy and exercise. She then went to see a chiropractor for treatment. An RS-4i interferential and muscle stimulator has been used on this patient for treatment, and the treating doctor is now requesting that this unit be purchased for this patient. He stated in a letter that this unit has helped her chronic low back pain.

#### 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

The \_\_\_ reviewer does not find that the purchase of the requested RS-4i unit is reasonable and necessary for the treatment of this patient's back problem. There is insufficient explanation of the benefits that the patient gets from this device. There is insufficient documented evidence that the worker has been able to decrease the use of pain medication, nor was she able to objectively increase her range of motion as a result of the use of this device. There is no creditable evidence in orthopedic literature that establishes the effectiveness of electrical stimulation for the treatment of back pain. The benefit for permanent use of the electrical stimulator has not been established and is not felt to be within the standard of care for back pain.

\_\_\_ 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 12<sup>th</sup> day of July 2004.**