

July 19, 2004

MDR Tracking #: M2-04-1483-01  
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

The records reviewed note that the patient has upper and lower back pain with myofascial pain as a result of a work-related injury on or about \_\_\_. She is an employee of \_\_\_\_\_. Her diagnoses include myofascial pain, right rhomboideus strain, thoracic pain and lumbar pain.

Records from \_\_\_ dated March 8 and March 22, 2004 reveal the patient has pain in the upper back region. The doctor states there is "no underlying thoracic spine problem there to be driving it." It is noted the patient has occasional "cervical symptomatology with occasional radiation into the right arm, which is in the same side as the myofascial symptoms." The physician notes the myofascial injections have improved some of her symptomatology. She states, "The underlying cause of her symptoms is not yet elucidated." The patient was recommended to continue with medication.

He further states on March 22, 2004, that the patient is using a deep muscle stimulator between December 2003 and January 25, 2004, and that the patient has used this several times. This appears to decrease some of her pain. He recommends continued use of this device.

Please note that the physical examination reveals the patient has decreased range of motion of the cervical spine but is neurologically intact. There re no further diagnostic studies for my review.

#### REQUESTED SERVICE

The purchase of an RS-4i interferential and muscle stimulator is requested for this patient.

## DECISION

The reviewer disagrees with the prior adverse determination.

### BASIS FOR THE DECISION

\_\_\_ has sustained a work-related injury while employed for \_\_\_ on \_\_\_. Diagnoses include myofascial pain syndrome, right rhomboideus strain, thoracic pain and lumbar pain of undetermined etiology.

To date, this patient has been given physical therapy, unnamed oral medications and steroid injections. She has also been advised to use a muscle stimulator.

Based on the medical records provided and the supporting documentation on the efficacy of an electrical stimulator, the reviewer finds that the request of the RS-4i stimulator is a reasonable treatment for this patient with myofascial pain syndrome.

\_\_\_ 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 19<sup>th</sup> day of July, 2004.**