

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** July 14, 2004

**RE: MDR Tracking #:** M2-04-1512-01  
**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 Orthopedic reviewer (who is board certified in Orthopedic Surgery) 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:**

- Letter of medical necessity dated 2/11/04 from \_\_\_
- Letter of medical necessity dated 4/8/04 from \_\_\_
- Clinical notes from \_\_\_ including \_\_\_ prescriptions and \_\_\_ patient health report and patient usage report

### **Submitted by Respondent:**

- Peer review report dated 4/29/04
- Peer review report dated 5/7/04
- Functional capacity evaluation by \_\_\_ dated 3/22/04
- Clinical office notes of \_\_\_
- Operative reports of epidural steroid injections dated 3/22/04 and 3/24/04
- MRI report dated 1/7/04
- Clinical notes from \_\_\_ dated 10/30/03

### **Clinical History**

The claimant has a history of chronic low back pain allegedly related to a compensable injury on \_\_\_. During use of \_\_\_ stimulator, the claimant underwent a series of three epidural cortisone injections.

**Requested Service(s)**

Purchase of RS-4i sequential four channel interferential muscle stimulator.

**Decision**

I agree with the insurance carrier that the requested intervention is not medically necessary.

**Rationale/Basis for Decision**

Generally, TENS and other transcutaneous stimulators should be used for acute pain and usually for no longer than 4-6 weeks. If the stimulator is needed beyond the acute phase, objective documentation should be provided for a continued rental/purchase. Objective documentation generally takes the form of a clinical trial and includes documentation of significant gains in objective parameters including range of motion and functional capacity, and decreased use of pain medications. Improvement from other interventional therapies such as epidural steroid injections are attributable to those interventional treatments and not to the stimulator. Upon review of all documentation provided, there is no documentation of a clinical trial with record of objective measurements of range of motion, functional capacity and pain medication use prior to onset of use of the device and after its use to indicate any significant improvement. Furthermore, there is documentation of interventional therapies in the form of epidural steroid injections times three and any gains would be attributable to those interventional treatments and not to the stimulator.

**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 14th day of July 2004.