July 30, 2004

MDR Tracking #: M2-04-1541-01
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 Neurology. 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 30 year old male who was working as a machine operator. He injured his back on ___ while he and a coworker were lifting a piece of iron, and the iron fell and ___developed severe low back pain. He ultimately underwent lumbar spine surgery in 06-2001 by ___. There are no actual records submitted from ___.

After surgery, ___continued to have problems with progressively worsening lower back pain. He was seen by ___, an orthopedic surgeon, on 1-07-2002. ___documented the claimant had normal strength and reflexes with no atrophy. He had positive straight leg raising on the right and positive paraspinal muscle spasm. He described his gait as "1+ antalgic on the right" with a wide base. ___reviewed an MRI of the lumbar spine, which was obtained on 10-19-2001 approximately 3 months after ___ initial surgery. This showed a large right posterolateral disk herniation at L5-S1 with postoperative changes. Also ___reviewed a CT myelogram performed on 11-21-2001, which showed a moderately sized posteroventral L5-S1 disk protrusion. ___ initial impression was recurrent right L5-S1 disk herniation with right lumbosacral radiculopathy. He recommended an L5-S1 arthrodesis with spinal instrumentation. He was seen again on 1-22-2004. He had last been seen in 8-2003, but there were no office notes from ___submitted during that time. Evidently, ___underwent an EMG and nerve conduction studies conducted by ___ on 12-11-2003, which showed no evidence of radiculopathy, plexopathy, or peripheral neuropathy effecting lower extremities. ___continued to complain of pain in his right lower extremity and was noted by ___to have weakness in his right quadriceps and tibialis anterior and an antalgic gait.

Review of his lumbar spine x-ray showed good placement of the L5-S1 spinal instrumentation with good solid fusion. He felt there was no further indication for surgery and recommended referral to ___ for chronic pain management.

Records from ___ from the ___ were reviewed. These cover a period of service from 1-02-2003 through 7-07-2004. On the initial evaluation of 1-02-2003, ___indicated ___had normal right leg strength, but mild left leg weakness. He recommended 3 caudal epidural injections. These were performed uneventfully but had no long lasting affect. He also entered into a chronic narcotic pain management contract with ___. In subsequent visits, ___prescribed a variety of medications including Neurontin, OxyContin, Oxycodone, Norco and Zanaflex. He also performed multiple trigger point injections. His diagnosis was postlaminectomy syndrome, lumbar radiculopathy, and myofascial fibrosis. In 9-2003, ___recommended interferential stimulation therapy. He received the interferential stimulator treatment for several months and noticed an improvement in his sleep. He continued however to have lower back pain and right leg pain and continued to require narcotics plus Neurontin and Zanaflex. ___ultimately recommended indefinite use of the interferential stimulator. He wrote a letter of medical necessity on 4-29-2004 requesting purchase of the RS4i muscle stimulator unit.

Two previous peer reviews, one performed by ___, and anesthesiologist, on 5-11-2004 and one performed by ___, also an anesthesiologist, on 5-14-2004 did not find that prolonged treatment with interferential stimulator unit was medically necessary or appropriate. Both previous reviewers performed physician peer-to-peer teleconferences with ___.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of the purchase of an RS4i sequential stimulator 4-channel combination interferential and muscle stimulator unit.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

___has failed laminectomy syndrome with evidence of persistent lumbar region pain and persistent neurologic deficit including weakness of his right lower extremity, and sensory disturbance in his right lower extremity. He has not undergone any postoperative electrodiagnostic studies. His imaging studies have only consisted of plain lumbar x-rays following his L5-S1 fusion. His pain has not responded to caudal epidural injections, trigger point injections, and multiple pharmacologic regimens. Consideration was given at one time to a spinal cord stimulator, but apparently this was never pursued. Subjectively the claimant has reported improvement with the use of the interferential stimulator, but it is not clearly documented that there has been a persistent benefit. Recommended guidelines indicate use of interferential stimulator in two settings; muscle atrophy due to disease and spinal cord injury.[1] There are no peer reviewed, randomized, placebo controlled studies published indicating long term benefit of interferential muscle stimulation in long term pain management.[2, 3]

References:
1. Medicare Compliance Manual 2003 pp 917-918
2. Minder, PM Interferential therapy; lack of effect upon experimentally induced delayed onset muscle soreness. Clin Physiol Funct Imaging, 2002 (22): 339-347
3. Glaser, J. Electrical Muscle Stimulation as an adjunct to exercise therapy in the treatment of non-acute low back pain: a randomized trial. The Journal of Pain, 2001 (2): 395-400

___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. ___believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of ___, Inc, dba ___, 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 2nd day of August 2004.