

July 29, 2004

MDR Tracking #: M2-04-1546-01

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

___ was injured on ___ while trying to stand from working in a crouched position for approximately 4 hours and experienced numbness and weakness in both legs. His right leg improved within 15 minutes, but the left leg took several hours and never actually recovered completely. An MRI of the lumbar spine revealed the following findings: L1/2 moderate foraminal encroachment, L2/3 disk protrusion and facet hypertrophy yielding bilateral recess compromise and central canal stenosis, L3/4 disk protrusion, mild facet hypertrophy, L4/5 demonstrated postoperative changes with enhancing soft tissue seen in the right lateral recess with non-enhancing component of disk protrusion and osteophytes and lateral recess compromise due to disk protrusion and scar tissue on the right recess, L5/S1 desiccation and protrusion of disk (mild) yielding foraminal encroachment on the left. ___ recommended physical therapy on 8/27/01. ESI's were recommended but ___ declined to perform them due to ___ diabetes. ___, spine specialist, saw the patient on 1/14/02 when he recommended ESI treatment at L4/5. EMG indicated L5 and S1 chronic radiculopathy and diabetic neuropathy. ___ performed numerous pain management interventions until in February of 2004 he prescribed a neuromuscular stimulator for chronic pain.

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

There have been no controlled studies indicating persistent long-term benefit of the use of the RS4i neuromuscular stimulator. Review of multiple literature databases dating back to 2000 failed to reveal any peer-reviewed studies indicating persistent benefit of the device. The Glaser study submitted in support of the device (ref. no.1) does not indicate persistent or long-term benefit after the device is removed. The use of the RS4i stimulator is not medically accepted for the use of chronic low back pain or lumbosacral radiculopathy.

References: 1) Glaser, J.A. (electrical muscle stimulation as an adjunct to exercise in the treatment of non-acute low back pain; a randomized trial), a journal of pain, 2001; 2) 295 to 300

___ 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 30th day of July 2004.