

July 26, 2004

MDR Tracking #: M2-04-1549-01
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 45-year-old gentleman who sustained work-related injury on ___. The records note that he was lifting a heavy metal box with two other coworkers when he stepped on a pipe, causing him to lose his balance. In this accident he injured his lower back.

In 2001 this patient had a lumbar fusion at L5/S1. He is under psychiatric care for depression. He takes Celebrex, Elavil and Flexoril. He does smoke 1 1/2 packs of cigarettes daily.

He has had exhaustive diagnostic studies to include a lumbar myelogram on January 9, 2002, which demonstrated prior surgery at L5/S1 with degenerative disc disease at L4/5. A CT/myelogram on that same date demonstrated post-surgical changes at L5/S1 with disc bulge at L4/5.

His most recent physical examination performed on March 12, 2004 by ___ notes the patient has pain over his lumbar region. There is decreased ROM of the lumbar spine. He demonstrates positive straight leg raise bilaterally at 30 degrees. He also displays positive Lasegue's sign, positive Fabere's sign and positive Kemp's sign.

___'s cervical examination is consistent with tenderness to palpation. His neurological exam demonstrates motor strength of 4/5 in the lower extremities and 5/5 in the upper extremities. He uses a cane to walk.

His assessment was failed back surgery, lumbar discogenic pain, lumbar radiculopathy, cervical radiculopathy, cervical discogenic pain, cervical herniated nucleus pulposus and myofascial pain syndrome. He has been offered multiple interventions, one of which is muscle stimulation.

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

This patient is a 45-year-old gentleman who is status post L5/S1 decompression and fusion. He has chronic pain syndrome, as documented above.

Based on reasonable orthopedic and pain management protocol, the reviewer finds it reasonable for this patient to use the RS-4i sequential stimulator four-channel combination interferential and muscle stimulator unit to help his chronic pain syndrome. Of course, this would be one of multiple interventions to deal with his very complex pain problem.

___ 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 26th day of July 2004.