

August 4, 2004

MDR Tracking #: M2-04-1558-01

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

___ suffered an injury at work on ___. He was unloading cases of milk at a grocery store when the bottom case broke off and the other cases fell jerking his neck, right shoulder, and thoracic region. He presented to ___ on ___ and was noted to have spasms in his paraspinal muscle right greater than left, with slight swelling and tenderness over the right shoulder. He had thoracic spine and right shoulder x-rays which were unremarkable. He was advised to take Motrin. He started seeing a chiropractor.

___ came under the care of ___ of the ___. Notes from ___ indicate dates of service from 6-27-2002 through 11-11-2003. ___ performed an initial orthopedic evaluation on 6-27-2002. His diagnostic impression was status post work related injury ___, continued right shoulder pain, rule out rotator cuff tear, type 2 acromion right shoulder per radiographs, mild right AC DJD per radiographs, cervical strain, rule out cervical HNP, right upper extremity radiculopathy, loss of cervical lordosis by radiographs, thoracic musculoskeletal low back pain, rule out HNP and rule out compression fracture.

An MRI of the cervical spine was normal. An MRI of the thoracic spine showed significant osteophyte/disk herniation indenting the cord at the level of T6-7 closer to the inferior endplate of T6, a protruding disk herniation extending cephalad from the disk space of T8-9, and milder osteophytic ridging at the discovertebral junction of T3-4 and T4-5. ___ obtained a right

shoulder arthrogram, which showed no evidence of a full-thickness rotator cuff tear. This was performed on 7-02-2002. ___ ultimately performed right shoulder surgery at the ____. This consisted of a right NEER acromioplasty and coracoacromial ligament resection. The date of surgery was 8-13-2003. Also the claimant received treatments for his neck and thoracic region pain consisting of thoracic and cervical epidural injections performed by ____, an anesthesiologist and pain specialist. These were performed on 6-23-2003, 7-24-2003, and 8-13-2003. Also the claimant was referred for physical therapy and work hardening. He was also seen by ____, a physiatrist, on 5-03-2004 for follow-up on his chronic neck, chronic shoulder pain, and upper back pain ___ recommended treatment with an interferential/neuromuscular stimulator unit, which appeared to reduce some of the patient's complaints of pain.

REQUESTED SERVICE

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

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

___ had an injury to the neck, shoulder, and thoracic region as a result of a work related accident on ____. His physical examination and neurologic examination showed no evidence of neurological deficit. He has been treated appropriately with physical therapy and has received thoracic epidural steroid injections. He underwent a right NEER acromioplasty, which resulted in improvement in his right shoulder pain. He has continued to work although on light duty. He has successfully completed a chronic pain management program. He is wishing to come off opiate medications. It is not known if the claimant had an EMG or nerve conduction studies performed. His current medication dosages and consumption are not documented. Subjectively he reports improvement in his pain when using the RS4i stimulator unit.

There have been no peer reviewed double-blind placebo controlled trials indicating sustained benefit of this device in chronic neck, shoulder, or thoracic region pain. Medicare usage guidelines indicate that the device is approved only for disuse atrophy or spinal cord injury. One study has been published looking at this intervention as a treatment for chronic shoulder pain and found that it was not effective.

References

Alves-Guerreiro, J., J.G. Noble, A.S. Lowe and D.M. Walsh, 2001. the effect of three electrotherapeutic modalities upon peripheral nerve conduction and mechanical pain threshold. *Clinical Physiology* 21 (6): 704-711.

Glaser, J.A., M.A. Baltz, P.J. Niertert and C.V. Bensen. 2001. 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* 2 (5): 295-300.

Johnson, M.I. and G. Tabasam 2003. An investigation into the analgesic effects of interferential currents and transcutaneous electrical nerve stimulation on experimentally induced ischemic pain in otherwise pain-free volunteers. *Physical Therapy* 83 (3): 208-223.

Medicare Compliance Manual 2003: 917-918.

Minder, P.M., J.G. Noble, J. Alves-Guerreiro, I.D. Hill, A.S. Lowe, D.M. Walsh and G.D. Baxter, 2002. Interferential therapy: Lack of effect upon experimentally induced delayed onset muscle soreness. *Clinical Physiology and Functional Imaging* 22 (5): 339-347.

Palmer, S.T., D.J. Martin, W.M. Steedman, and J. Ravey, 1999. Alteration of interferential current and transcutaneous electrical nerve stimulation frequency: Effects on nerve excitation. *Archives of Physical Medicine and Rehabilitation* 80: 1065-1071.

Taylor, K., R.A. Newton, W.J. Personius and F.M. Bush, 1987. Effects of interferential current stimulation for treatment of subjects with recurrent jaw pain. *Physical Therapy* 67 (3): 346-350.

Van der Heijden, G., P. Leffers, P. Wolters, J. Verheijden, H. van Mameren, J. Houben, P. Knipschild, 1999. No effect of bipolar interferential electrotherapy and pulsed ultrasound for soft tissue shoulder disorders: a randomized controller trial. *Annals of Rheumatic Diseases* 58: 530-540.

___ 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 ___, 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 5th day of August, 2004.