

July 28, 2004

MDR Tracking #:
IRO #:

M2-04-1610-01
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

On ___, ___ was working as a ___ when she sustained injury to her lower back as a result of lifting an 80-pound mentally challenged student. She is now 59 years old. At the time of her injury she noted severe pain in the lower back with radiation into the back of both hips and down both legs, worse on the left side. She had a history of previous multiple back surgeries and laminectomies and fusion at the L4/5 and L5/S1 joints. ___, a spine surgeon, worked her up and found her to be a candidate for surgical treatment, since all non-surgical treatment had failed to give her any relief of symptoms.

She was taken to surgery on May 23, 2003 and a laminectomy and decompression procedure was carried out at the L3/4 level with fusion at that level. The patient also had durotomy with removal of dural scar and nerve root adhesions at the L4/5 level.

Following surgery, the patient has continued to have chronic pain in the low back with radiation into both legs. She is continuing to see ___ for follow-up care. He has used an RS muscle stimulator on her and it was used beginning 12/23/03. She reported that the stimulator gave her some relief of symptoms and he has now requested the purchase of this device.

REQUESTED SERVICE

The purchase of an RS-4i interferential and muscle stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The documentation provided for review does not give any credible evidence that the muscle stimulator has been of any value in helping to heal this patient's lower back pain. There is no creditable evidence in the orthopedic literature that establishes the effectiveness of electrical stimulation for the treatment of back pain. The benefit for permanent use of the electrostimulator has not been established. The unit requested is

not felt to be within the standard of care for low back pain. The amount of pain medicine that has been prescribed has not been decreased since this patient began to use the RS-4i in December 2003. It is for these reasons that the reviewer does not find the purchase of the requested RS-4i interferential and muscle stimulator to be medically necessary.

___ 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 28th day of July, 2004.