

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 19, 2004

RE: MDR Tracking #: M2-05-0091-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Anesthesiology/Pain Management reviewer (who is board certified in Anesthesiology/Pain Management) who has an ADL certification. The physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Submitted by Requester:

- Office notes from ___ dated 1/6/04, 2/16/04, 4/19/04, and 6/24/04
- Prescriptions for ___ equipment dated 4/27/04 and 6/24/04
- Appeal letter from ___ dated 6/23/04

Submitted by Respondent:

- Office notes from ___ dated January-June 2004
- ___ prescription from 6/24/04
- Pre-authorization denial letters from 7/9/04 and 8/5/04
- Appeal letters from ___ dated 6/23/04 and ___ dated 8/2/04

Clinical History

I do not have any notes pertaining to the actual date of injury or a description of the injury. The first note I have is from ___ at which time the patient complained of back and bilateral knee pain. Because of the patient's complaints of low back pain, muscle spasm and decreased range of motion, she was given a prescription for an RS-4i interferential muscle stimulator unit in April 2004. The patient continued use of this through June 2004 at which time a prescription was written for purchase of the unit.

Requested Service(s)

Purchase of an RS-4i sequential four channel combination interferential and muscle stimulator unit.

Decision

I agree with the insurance carrier that the requested services are not medically necessary.

Rationale/Basis for Decision

The requesting physician does not provide accurate documentation that there has been any improvement of the patient's symptomatology with use of the muscle stimulator interferential unit. The patient's complaints of pain are not documented to have improved. There are verbal analog scores prior to the trial. None are included after or during the trial. There is an authorization letter from one of the reviewing physicians who states that in June the patient's pain was rated at 9/10, which would be documentation of no significant improvement in her pain symptoms. There is also no improvement if the patient has had improved functioning with use of the unit. She had returned to work as of January 2002. There is also no documentation to support decreased functioning otherwise. In conclusion, the requesting physician has not appropriately documented any effectiveness of this unit in treating the patient's symptoms or documented any improvement in the patient's functioning with this unit. Therefore, recommendation for the unit is not medically necessary or indicated.

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.

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.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 19th day of October 2004.