

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 20, 2004

RE: MDR Tracking #: M2-05-0115-01
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 with added qualifications in 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:

- RS4i standard prescription form and computerized form letter signed by the provider
- Notes from ___
- ___ "Patient Health Report" and "Patient Usage Report"

Submitted by Respondent:

- Adverse utilization review decisions (multiple), including appeals
- TWCC paperwork, including Table of disputed services
- ___ notes (as also provided by the provider)
- Notes from ___
- Proprietary literature supporting the device, provided by the manufacturer

Clinical History

The injured worker has shoulder pain and spasms that developed in ___. He underwent a surgical procedure in September of 2001 and has been treated recently with topical anti-inflammatories and Bextra. The notes are sketchy, but there have been several peer reviews. The peer review by ___ indicates that the patient has a stimulation unit at home that has never been taken out of the box. The RS-4i is a second unit. There is an indication in the ___

documentation that there is some benefit from this device. ___ note of 7/13/04 indicates that the patient's pain level has decreased in his muscle and his pain medications have been decreased. The review by ___ on 8/4/04 indicates that ___, a member of ___ office staff, indicates that Bextra continues to be prescribed.

Requested Service(s)

Purchase of an RS4I sequential, 4 channel combination interferential and muscle stimulator unit.

Decision

I agree with the insurance carrier that the requested service is not medically necessary.

Rationale/Basis for Decision

There are conflicting reports in that ___ indicates pain relief, although he does not quantify the relief. ___ indicates that the pain medications have been decreased, but ___ indicates that Bextra has been continued. There are indications from previous peer reviewers that the patient has improved and is back to work. There is inadequate documentation that the RS-4i is providing significant relief to justify purchase.

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 20th day of October 2004.