

November 2, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-0160-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**----- Case #:**

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ----- external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurology and is familiar with the condition and treatment options at issue in this appeal. The ----- physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a male who sustained a work related injury on ----- . The patient has been diagnosed with lumbar disc protrusion, lumbar sprain, sciatica and lumbar subluxation. The treatment for this patient have included pain medications, chiropractic treatment, and heat/ice. The patient has also been treated with an RS4i sequential stimulator to reduce muscle spasms, relieve acute pain, and reeducate muscles. The purchase of an RS4i sequential stimulator has been recommended for further treatment of this patient's care.

### Requested Services

Purchase of an RS4i sequential, 4 channel combination interferential & muscle stimulator.

### Documents and/or information used by the reviewer to reach a decision:

*Documents Submitted by Requestor:*

1. RS Medical Prescription 5/24/04, 7/22/04
2. Treatment Notes 7/1/04 – 7/8/04
3. Letter of Medical Necessity 7/19/04
4. RS Medical Patient Usage Report 8/20/04

*Documents Submitted by Respondent:*

1. Response to Request for Records 10/12/04
2. Emergency Room Report 5/7/04
3. MRI report 5/7/04
4. Comprehensive Medical Analysis 7/8/04

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a male who sustained a work related injury to his back on -----, The ----- physician reviewer also noted that the diagnoses for this patient have included lumbar disc protrusion, lumbar sprain, sciatica and lumbar subluxation. The ----- physician reviewer further noted that the treatment for this patient's condition has included pain medications, chiropractic treatment, heat and ice, and that the purchase of an RS4i sequential stimulator has been requested for further treatment of this patient's condition. The ----- physician reviewer explained that there is no evidence provided that demonstrated the patient had improved after treatment with the requested stimulator. The ----- physician reviewer also explained that the long-term use of the requested neuromuscular stimulator has not been proven beneficial. Therefore, the ----- physician consultant concluded that the requested purchase of an RS4i sequential, 4 channel combination interferential & muscle stimulator is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

**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)** days of your receipt of this decision. (20 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)** 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/Appeals Clerk  
P.O. Box 17787  
Austin, TX 78744

Fax: 512-804-4011

**A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

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State Appeals Department

cc: Texas Workers Compensation Commission

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 2nd day of November 2004.

Signature of IRO Employee

Name