

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 22, 2004

RE: MDR Tracking #: M2-05-0185-01
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 Orthopedic Surgeon reviewer (who is board certified in Orthopedic Surgery) 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:

- Letter of medical necessity by ___ dated 7/8/04
- Clinical ___ documents dated 4/9/04 and 5/25/04

Submitted by Respondent:

- Peer review analysis dated 8/3/04
- Appeal analysis dated 10/1/04
- ___ product information

Clinical History

The claimant has a history of chronic right neck and shoulder pain allegedly related to a compensable injury that occurred on or about ___. The claimant is status post rotator cuff repair. Stimulator is prescribed for a diagnosis of "brachial neuritis".

Requested Service(s)

Purchase of RS4i Sequential 4 channel combination interferential and muscle stimulator

Decision

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

Rationale/Basis for Decision

Generally transcutaneous, interferential, and neuromuscular stimulators should be used for acute pain and usually for no longer than 4-6 weeks. If stimulators are needed beyond the acute phase, objective documentation should be provided for continued rental or purchase. The claimant is over 10 months status post rotator cuff repair and exhibits a functional range of motion. There is no EMG/NCV study data to support a diagnosis of brachial plexus neuritis. Long term use of stimulators is appropriate when there has been at least a 2 month trial to determine effectiveness in significantly increasing range of motion and functional capacity and decreasing use of pain medications and use of other medical services. Upon review of the ___ documents, treatment plan indications include maintaining or increasing range of motion and preventing or retarding disuse atrophy. However, there is no objective documentation of measures of strength, muscle circumference, or range of motion prior to onset of use of the device and after its use to indicate any significant improvement over time in these parameters. There is no clearly documented clinical rationale explaining why usual and customary conservative measures of treatment including but not limited to conventional ice/heat modalities and a well structured home exercise program would be any less effective than purchase of an ___ device in this clinical setting.

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 22nd day of October 2004.