

November 5, 2004

**RE: MDR#:** M2-05-0193-01      **Injured Employee:** \_\_\_\_  
**TWCC#:** \_\_\_\_      **DOI:** \_\_\_\_  
**IRO Certificate #:** 5055      **SS#:** \_\_\_\_

**TRANSMITTED VIA FAX TO:**

**Texas Workers' Compensation Commission**

Attention: \_\_\_\_  
Medical Dispute Resolution  
Fax: 512-804-4868

**REQUESTOR:**

RS Medical  
Attn: Joe Basham  
Fax: (800) 929-1930

**RESPONDENT:**

Fidelity & Guaranty Ins. c/o FOL  
Attn: Kelly Pinson  
Fax: (512) 867-1733

Downs & Stanford  
Attn: Wendy Schrock  
Fax: (214) 748-4530

Downs & Stanford  
Attn: Gaylyn  
Fax: (214) 747-2333

**TREATING DOCTOR:**

Ronald Fraser, M.D.  
Fax: (281) 558-0068

Dear Ms. \_\_\_\_:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your care to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc., and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or

other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is board certified in Pain Management and Neurology and is currently listed on the TWCC Approved Doctor List.

## **REVIEWER'S REPORT**

### **Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOBs

Information provided by Requestor:

- Letter of medical necessity 06/22/04
- Office notes 03/18/04 – 06/25/04
- Physical therapy notes 03/24/04 – 06/25/04
- Radiology report 07/24/04

Information provided by Respondent:

- Summary of carrier's position 10/05/04
- Relevant articles

### **Clinical History:**

This claimant suffered from a work-related injury on \_\_\_ that resulted in some lumbar spine pain. The pain is located in the low back with radiation into the left lower extremities to the level of the knees. X-rays have reportedly been negative. The patient has been treated with oral steroids, as well as short-acting narcotics, physical therapy, and recently a muscle stimulator device, has offered significant pain relief, reducing her usage of pain medication, as well as increasing physical activity around the house, etc.

### **Disputed Services:**

Purchase of RS4i sequential stimulator 4-channel combination interferential and muscle stimulator unit.

### **Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that purchase of the equipment in dispute as stated above is medically necessary in this case.

### **Rationale:**

This claimant has clearly benefited from this device, which as resulted in a reduction in her usage of pain medication and has increased her ability to partake in daily activities at home, etc. In the reviewer's experience, muscle pain components due to chronic spine conditions can be longstanding and may require long-term treatment. Because this

treatment would be considered safe for long-term use, and has been quite effective for this claimant, it would be reasonable to continue usage of this treatment long term.

### **YOUR RIGHT TO REQUEST A HEARING**

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. is deemed to be a Commission decision and order.

Either party to this medical dispute may disagree with all or part of this decision and has the right to request a hearing.

**If disputing a prospective spinal surgery decision**, a request for a hearing must be in writing and must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admn. Code 142.5c).

**If disputing other prospective medical necessity (preauthorization) decisions**, a request for a hearing must be in writing and must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admn. Code 148.3).

The decision is deemed received by you five (5) days after it was mailed (28 Tex. Admn. Code 142.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission, MS-48  
7551 Metro Center Dr., Ste. 100  
Austin, TX 78744-1609

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.

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 US Postal Service from this IRO office on November 5, 2004.

Sincerely,

Secretary & General Counsel