

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** November 1, 2004

**RE: MDR Tracking #:** M2-05-0194-01  
**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 a 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:**

- Office notes of \_\_\_
- Letter of medical necessity by \_\_\_, dated 7/20/04
- \_\_\_ medical prescription dated 7/21/04
- \_\_\_ medical prescription dated 4/21/04

### **Submitted by Respondent:**

- TWCC pre-authorization report and notification dated 7/27/04, 8/11/04
- \_\_\_ pre-authorization IPA review request form dated 7/29/04

### **Clinical History**

The claimant has a history of chronic shoulder pain allegedly related to a compensable injury on \_\_\_\_\_. The claimant has undergone left rotator cuff in April 2004 and a right rotator cuff in August 2004.

### **Requested Service(s)**

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

### **Decision**

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

## **Rationale/Basis for Decision**

Generally transcutaneous stimulators should be used for acute pain and usually for no longer than 4 to 6 weeks. If stimulators are needed beyond the acute phase objective documentation should be provided for continued rental/purchase. Objective documentation should indicate improvement over time with use of the device. Prior to initiating use of the device the physician should document current range of motion, current use of pain medication and current functional capacity. Prior to any extension of the use these objective factors should be measured again and indicate significant benefit from use of the device. \_\_\_ medical prescription dated 7/21/04 does not include objective documentation of improvement over time in the above mentioned parameters. In the absence of any proven benefit by measurable parameters, a reasonable standard for purchase is not documented. There is no clearly documented clinical rationale explaining why a well structured home exercise program, conventional ice/heat modalities, and over the counter medication would be any less effective than use of the requested DME 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 1st day of November 2004.