

November 15, 2004

Re: **MDR #:** M2-05-0264-01 **Injured Employee:**
 TWCC#:
 IRO Cert. #: 5055 **DOI:**
 SS#:

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REQUESTOR:

RESPONDENT:

TREATING DOCTOR:

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ 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 ___ 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 in Neurology and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- Correspondence
- Office notes 07/16/04 – 08/09/04
- Physical therapy notes 04/10/04 – 10/08/04

Information provided by Respondent:

- Correspondence and documentation

Information provided by Treating Doctor:

- Office notes 08/08/04 – 11/08/04

Clinical History:

This claimant, who sustained a work-related injury on ____, has had chronic low back and neck pain along with some radicular symptoms. There is clear documentation of a muscle spasm/myofascial components and spine pain as well. This claimant has been treated with medications including short-acting narcotics, as well as Soma, and a muscle stimulator device. Information from the claimant's physician as well as the claimant indicate the muscle stimulator device has been quite helpful in relieving the chronic pain and reducing the muscle spasms, resulting in increased mobility for the patient. It is not entirely clear from the documentation whether this has translated in reduced usage of pain medications.

Disputed Services:

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

Decision:

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

Rationale:

From the limited medical records available, it is rather clear that both the patient and the treating physician feel that the muscle stimulator unit has translated to significant symptomatic relief for this chronic pain condition, and that this has also translated to increased mobility for the patient. One would assume that this has also translated to some reduction in analgesic usage, though this is not clearly indicated in the notes available. However, given the efficacy of this unit, and the longstanding nature of the pain condition, as well as the safety and tolerability of this device, I feel that it would be medically reasonable to allow this claimant use of this device for long term.

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

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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
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 U.S. Postal Service from the office of the IRO on November 15, 2004.