

November 24, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-0268-01**  
**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 neurosurgery 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 female who sustained a work related injury on ----- . The patient reported that while at work she injured her back while lifting boxes. X-Rays performed on 4/7/04 were negative for fracture, stenosis, sUBLUXATION, and anterior osteophyte formation. On 6/26/04 the patient underwent an MRI of the lumbar spine that indicated a disc desiccation without loss of height, a 3.5mm broad-based posterior right paracentral subligamentous protrusion minimally indenting the sac, and no central canal stenosis or marked foraminal narrowing. The initial diagnoses for this patient included lumbar intervertebral disc syndrome, lumbar radiculopathy, and lumbosacral sprain and strain. The current diagnosis for this patient is lumbago. Treatment for this patient's condition has included a neuromuscular stimulator and a series of anesthetic injections. The purchase of an RS4i sequential stimulator has been recommended for further treatment of this patient's condition.

### Requested Services

RS4i Sequential, 4 channel combination interferential and muscle stimulator.

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

*Documents Submitted by Requestor:*

1. RS Medical Prescription 6/11/04, 8/13/04
2. Letter of Medical Necessity 8/11/04

*Documents Submitted by Respondent:*

1. Independent Review Organization Summary 11/1/04
2. X-Ray report 4/7/04
3. Procedure Note 6/15/04
4. MRI report 6/26/04, 6/29/04, 7/6/04
5. Electrodiagnostic evaluation report 8/6/04
6. Progress and Daily Notes 6/9/04 – 9/22/04.

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 female who sustained a work related injury to her back on -----. The ----- physician reviewer also noted that the current diagnosis for this patient is lumbago and that treatment for this patient's condition has included the use of an RS4i Sequential Stimulator. The ----- physician reviewer further noted that the purchase of an RS4i Sequential Stimulator has been requested. The ----- physician reviewer explained that there is no objective evidence indicating the clinical efficacy of the RS4i Sequential Stimulator for the treatment of this patient's diagnosis. The ----- physician reviewer also explained that there are no prospective randomized, double blind studies demonstrating the efficacy of the use of the requested device for the treatment of this patient's condition. Therefore, the ----- physician consultant concluded that the requested purchase of an RS4i Sequential, 4 channel combination interferential and 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 24th day of November 2004.

Signature of IRO Employee

Name