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NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 21, 2004

Requester/ Respondent Address:

TWCC
Attention: Gail Anderson
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-1609

RS Medical
Attn: _____
Fax: 800-929-1930
Phone: 800-462-6875

Farmers Ins. Group of Companies
Attn: _____
Fax: 512-343-1385
Phone: 512-343-1300

RE: Injured Worker:

MDR Tracking #: M2-05-0446-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 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:

- RS Medical prescription documents dated 9/16/04 and 7/22/04
- Clinical documents of Dr. B, M.D.
- Clinical documents of Southwest Neuroscience and Spine Center

Submitted by Respondent:

- Texas Medical Foundation peer review
- Independent review determination by Medical Review of Texas
- Legal documents by Stone, Laughlin and Swanson, LLP

Clinical History

The claimant has a history of chronic back pain allegedly related to a compensable injury on _____. The claimant is status post left L5-S1 microdiscectomy.

Requested Service(s)

Purchase of RS-4i sequential four 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 electric nerve stimulation and other transcutaneous 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/purchase. A review of the treatment plan and indications in the RS Medical prescription indications include prevention and retardation of disuse atrophy and maintenance and increase in range of motion. However, under ‘Patient Progress Report’ there is no documentation of range of motion or muscle circumference to indicate any objective improvement. Generally, objective parameters are measured prior to onset of use of device and after its use to confirm significant improvement over time with use of the device. Individual clinical trials are indicated due to a lack of support for use of this device in management of chronic pain. There is no documentation of exhaustion of usual and customary conventional methods of treatment including, but not limited to, oral non-steroidal and corticosteroid medications, bracing, and physical therapy emphasizing dynamic spinal stabilization.

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 21st day of December 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: