



Specialty Independent Review Organization, Inc.

January 19, 2005

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M2-05-0497-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Medical Doctor who is board certified in Pain Management and Anesthesiology. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This 36 year old female was injured at work on ___ and has had epidural steroid injections, facet joint injections, physical therapy and a lumbar fusion.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of a RS4i sequential 4 channel combination interferential and muscle stimulator.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer states that the long term effectiveness of interferential therapy has not been established in peer-reviewed medical literature. The following studies support this conclusion.

Alves-Guerreiro, J, et al. (“The effect of three electrotherapeutic modalities upon peripheral nerve conduction and mechanical pain threshold.” *Clinical Physiology*, 2001; 21(6): 704-711) compared the effect of three electrotherapeutic modalities on peripheral nerve conduction and mechanical pain threshold in a randomized, double-blind trial with a control group included 40 healthy volunteers. They found that there was no statistically significant differences for the mechanical pain threshold measurements.

Werners, R, et al. (“Randomized trial comparing interferential therapy with motorized lumbar traction and massage in the management of low back pain in a primary care setting.” *Spine*. 1999; 24 (15): 1579-1584) compared interferential therapy against motorized lumbar traction combined with massage in the management of low back pain. After 3 months of therapy, the Interferential therapy patients did not differ significantly from patients receiving lumbar traction with massage in disability or pain score improvement.

Additionally, the Philadelphia Panel Physical Therapy Study found little or no supporting evidence to include this modality in the treatment of chronic pain greater than 6 weeks.

RS Medical submits that a study by Glaser et al Supports its position. (Electrical muscle stimulation as an adjunct to exercise therapy in the treatment of non-acute low back pain: a randomized trial. Glaser JA, Baltz MA, Nieter PJ, Bensen CV.) However, of the 80 patients initially enrolled, 42 discontinued or withdrew before completing the entire study protocol. This renders the results invalid, since a majority did not complete the study.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee’s policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

____, CEO

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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, Texas Worker’s Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

____, CEO

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant’s representative) and the TWCC via facsimile, U.S. Postal Service or both on this ____19th____ day of __January____, 2005 __

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: