



7600 Chevy Chase, Suite 400  
Austin, Texas 78752  
Phone: (512) 371-8100  
Fax: (800) 580-3123

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** March 28, 2005

**Requester/ Respondent Address:**

TWCC  
Attention:  
7551 Metro Center Drive, Suite 100, MS-48  
Austin, TX 78744-1609  
TX 75212

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

Service Lloyds Ins Co c/o Harris & Harris  
Attn: Robert Josey  
Fax: 512-346-2539  
Phone: 512-346-5533

**RE: Injured Worker:**

**MDR Tracking #:** M2-05-1122-01  
**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 a orthopaedic surgery reviewer (who is board certified in orthopaedic 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.

March 28, 2005

Page 2

**Submitted by Requester:**

- Records from George Wharton, MD
- RS Medical prescription

**Submitted by Respondent:**

- Letter from Harris & Harris attorneys rejecting Rs4i Stimulator prescription.
- MD rationales for rejection (2)
- Records from Dr. Wharton
- Designated Doctor Summary

**Clinical History**

This was a repetitive lifting injury that occurred on \_\_\_\_\_. The claimant had complaints of low back pain radiating to left lower extremity with neurologic findings. The claimant failed conservative treatment. An MRI of the lumbar spine, showed an extruded disc at L4 and he underwent a microdiscectomy at L4 on 6-16-03; this was done by Dr. Wharton. This helped his radicular pain but he continued with back and thigh pain. He had 3 lumbar epidural steroid injections; however, they only gave temporary relief. He subsequently underwent a two-level fusion at L4 and L5 this was an anterior and posterior fusion. This procedure failed and his pain persists.

**Requested Service(s)**

Purchase of a RS4i sequential 4 channel combination interferential and muscle stimulator.

**Decision**

I agree with the insurance carrier that the above service is not medically necessary.

**Rationale/Basis for Decision**

There is no documentation in the records I have reviewed of improvement of functional levels using the above device. The record contains only anecdotal reports. There should always be a clinical trial of at least 60 days to monitor functional improvement, reduction in use of analgesics, and improved range of motion. In the records I reviewed, the above was not present. There are no independent evidence based scientific studies in the peer reviewed medical literature to support use of the RS4i stimulator. Therefore, the only way to evaluate the use of the RS4i stimulator would be to conduct an individual clinical trial with objective recording of improvement in physical functional capacity with the individual demonstrating physical activities that he could not perform before the stimulator was applied, and demonstrating

March 28, 2005

Page 3

decrease in the need for analgesics. In an ideal situation, the evaluation of the efficacy of the stimulator should be done by a qualified professional other than the prescribing physician, who is not aware of the individual's functional capacity and pain levels prior to prescribing the device.

### **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 28<sup>th</sup> day of March 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder