

April 8, 2005

VIA FACSIMILE
RS Medical
Attn: Joe Basham

VIA FACSIMILE
Travelers c/o FOL
Attn: Katie Foster

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-1132-01
TWCC #:
Injured Employee:
Requestor: RS Medical
Respondent: Travelers c/o FOL
MAXIMUS Case #: TW05-0059

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS 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 MAXIMUS for independent review in accordance with this Rule.

MAXIMUS 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 MAXIMUS 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 MAXIMUS 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 MAXIMUS for independent review. In addition, the MAXIMUS 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 _____. A letter of medical necessity indicates that the patient has been under care for chronic back pain and spasms. A follow up progress note dated 11/18/03 indicates that the patient had decompression fusion L3-L5 on 1/9/03 and previous unsuccessful posterior fusion L5-S1 with left hip and left thigh pain secondary to sacroiliac syndrome. A follow up note on 1/13/04 indicates that x-rays show no gross motion with flexion and extension and the previous posterior fusion L5-S1 is unchanged. Treatment for this patient's condition has included surgery, medications, sacro-iliac injections,

water therapy, and the use of an RS4i sequential stimulator. The purchase of the RS4i sequential stimulator has been recommended for continued treatment of this patient's condition.

Requested Services

Purchase of an 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. Followup Progress Notes: 9/27/04, 11/30/04
2. RS Medical Prescriptions 10/1/04, 11/17/04
3. Letter of Medical Necessity 11/22/04
4. RS Medical Patient Usage Report: 10/1/04-1/16/05
5. Undated Letter from Patient: date stamp received 2/9/05

Documents Submitted by Respondent:

1. Follow Up Notes: 11/18/03-11/30/04

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a female who sustained a work related injury on _____. The MAXIMUS physician reviewer also noted that the patient has had a greater than 10 year history of low back pain. The MAXIMUS physician reviewer explained that the patient has had spinal fusion twice. The MAXIMUS physician reviewer also explained that there is no evidence that the requested device is beneficial in the long term treatment of chronic lumbar back pain. Therefore, the MAXIMUS physician consultant concluded that the requested 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,
MAXIMUS

Elizabeth McDonald
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 8th day of April 2005.

Signature of IRO Employee: _____
External Appeals Department