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## 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

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

Liberty Mutual Ins Co  
Attn: Toni Evans  
Fax: 864-576-4473  
Phone: 864-574-8010 x 226

**RE: Injured Worker:**  
**MDR Tracking #:** M2-05-1172-01  
**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 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.

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**Submitted by Requester:**

- Office notes Stanley Gertzbein, MD
- Records from Robert Sickler, MD
- Prescription for RS4i stimulator

**Submitted by Respondent:**

- Peer Review notes and opinions.
- Notes from Dr. Sickler

**Clinical History**

This is a 48 year old female who sustained an injury at work on \_\_\_\_\_. She failed conservative treatment, and had a cervical laminectomy and fusion from C4-6 in April 2004. Post surgery she has continued with complaints of right neck and shoulder pain radiating to the interscapular region and to the lateral shoulder and arm area. Her past history indicates a "spine fusion" in \_\_\_\_\_, however, the level is not specified and rotator cuff injury in \_\_\_\_\_ and "back surgery" in \_\_\_\_\_, again, the level is not specified. Her cervical surgery done April 2004, was not successful, and an RS4i stimulator has been prescribed by Dr. Sickler. There is a December 2004 letter from Dr. Sickler describing improvement in pain and function, however, there is also evidence that her pain medicine, Zanaflex and Hydrocodone was increased in December 2004 and her pain level was 6/10 instead of 2/10.

**Requested Service(s)**

Purchase of a RS-4i muscle stimulator.

**Decision**

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

**Rationale/Basis for Decision**

There is no objective documentation in the records I reviewed of improvement of functional levels with use of the above device. The record contains only anecdotal reports. There should always be a clinical study of at least 60 days to monitor functional improvement, reduction in use of analgesics, and improved range of motion. In the records I reviewed, there is no careful objective documentation that the above goals were accomplished. There are no independent evidence based scientific studies in the peer reviewed medical literature to support the 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 she could not

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perform before the stimulator was applied, and demonstrating 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