

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER: 453-05-9150.M2

July 26, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TWCC #:

MDR Tracking #:

M2-05-1636-01

IRO #:

5251

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

IRO America 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.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed MD, board certified and specialized in Pain Management and Neurology. The reviewer is on the TWCC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who 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 IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **RECORDS REVIEWED**

Notification of IRO assignment, information provided by Requestor, Respondent, and Treating Doctor.

### **CLINICAL HISTORY**

This Patient sustained a work-related injury on \_\_\_ that has resulted in chronic lumbar spine pain. This Patient has undergone multiple treatment trials, including the use of a muscle stimulator device. She has also undergone treatment with multiple medications and physical therapy, as well as invasive procedures including an IDET procedure, etc. Information provided

by the Patient as well as her treating physician clearly demonstrates that the use of the muscle stimulator device has resulted in a decrease in pain with increased parameters such as sleep as well as reduction in medications, increased physical activity, etc. The Patient clearly reports in a

written note that the stimulator has been easy to use, convenient to travel with, and notes that she has continued to take some medications but that the quantity has “decreased greatly.”

### **DISPUTED SERVICE(S)**

Under dispute is the prospective and/or concurrent medical necessity of purchase of an RS-4i Sequential 4-channel Combination Interferential and Muscle Stimulator.

### **DETERMINATION/DECISION**

The Reviewer disagrees with the determination of the insurance carrier.

### **RATIONALE/BASIS FOR THE DECISION**

It is clear from the medical records provided that this Patient has undergone multiple treatment attempts and has found that the muscle stimulator device has not only resulted in a reduction in her pain but also has allowed her to improve her physical activity and functioning, improve her sleep, and reduce her medication usage. There are no adverse effects associated with the use of this device that she has reported. There is nothing in the records to indicate that the Patient or her treating physician are exaggerating or being untruthful. Therefore, the Reviewer believes that this Patient is an excellent candidate for the continued use of this device as prescribed indefinitely. The Reviewer believes that it is considered medically necessary for this particular claimant.

### **Screening Criteria**

General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by TWCC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

### **CERTIFICATION BY OFFICER**

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee’s policy.

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

IRO America is forwarding by mail or facsimile, a copy of this finding to the TWCC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

**IRO America Inc.**



Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**

Cc: RS Medical  
Attn: Joe Basham  
Fax: 800-929-1930

Ins. Co. of the State of PA  
Attn: Annette Moffet  
Fax: 512-867-1733

Dr. R. Vera  
Fax: 214-820-7464

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to 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.

Name/signature

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 26th day of July, 2005.

Name and Signature of Ziroc Representative:

Sincerely,

**IRO America Inc.**

A handwritten signature in black ink, appearing to read "Roger Glenn Brown", with a long horizontal flourish extending to the right.

Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**