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## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** June 29, 2005

**Requester/ Respondent Address:** TWCC  
Attention: Rebecca Farless  
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

American Home Assurance c/o Downs & Stanford PC  
Attn: Jon Grove  
Fax: 214-747-2333  
Phone: 214-748-7900

**RE: Injured Worker:**  
**MDR Tracking #:** M2-05-1717-01  
**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 Anesthesiology/Pain Management reviewer (who is board certified in Anesthesiology/Pain Management) 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.

**Submitted by Requester:**

- Letter from the claimant which is undated
- Prescription for the RS4i dated 8/31/04 and purchase on 10/10/04
- Letter of medical necessity from Dr. Barhorst dated 1/13/05

**Submitted by Respondent:**

- None provided

**Clinical History**

I have very limited records. The claimant's date of injury is \_\_\_\_\_. She complains of pain in the low back and buttocks area, and has been given diagnoses of lumbago and muscle spasm. She was prescribed a trial of an RS4i unit on 8/31/04. A request was made for purchase of the unit on 10/10/04.

**Requested Service(s)**

RS4i muscle stimulator purchase

**Decision**

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

**Rationale/Basis for Decision**

There is inadequate documentation that the RS4i muscle stimulator provided significant benefit for the claimant. The claimant did write a letter with the subjective statement that it did alleviate her symptoms. Subjective benefit needs to be translated into objective benefit. There is no documentation of decreased use of medications to corroborate this information, such as office notes showing fewer pills or refills prescribed. There are no measured pain scores to corroborate this information. There are no objective findings of increased functioning, increased range of motion or return to work. In conclusion, there is inadequate documentation to support the purchase of the RS4i muscle stimulator.

**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 29<sup>th</sup> day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder