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NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 31, 2005

Requester/ Respondent Address:

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

RS Medical/Jerry Keepers, MD
Attn: Joe Basham
Fax: 800-929-1930
Phone: 800-462-6875

Ins Co of the State of PA c/o FOL
Attn: Katie Foster
Fax: 512-867-1733
Phone: 512-435-2266

RE: Injured Worker:

MDR Tracking #: M2-05-2184-01

IRO Certificate #: IRO 5263

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:

- RS Medical prescriptions dated 2/24/05 and 4/22/05
- Re-evaluation note from Dr. Keepers dated 4/22/05
- Usage report and letter of medical necessity from Dr. Keepers dated 4/21/05

Submitted by Respondent:

- Letter of the “carriers position” dated 8/8/05
- Denial letters dated 6/1/05 and 6/17/05
- Article from the Center for Medicare Services dated 3/1/05
- Two articles from the Philadelphia Panel for Evidence Based Clinical Practice Guidelines on Scheduled Rehabilitation Interventions, one for low back pain and the second for neck pain dated October 2001
- Multiple independent review decisions regarding the RS-4i
- Internet information from regence.com and webmd.com

Clinical History

There is very little history in any of the information provided. The claimant’s date of injury is listed at ___ and does include the low back. As to how the injury occurred or what treatment modalities have been tried to this point, I have no information.

Requested Service(s)

Purchase of RS-4i sequential four channel combination interferential and muscle stimulator

Decision

I agree with the carrier that the services in dispute are not medically necessary.

Rationale/Basis for Decision

The unit itself is very poorly established in clinical studies as being effective for chronic pain in the low back. The claimant’s personal usage of the unit shows no documented efficacy at alleviating the claimant’s symptomatology or improving the claimant’s functioning, range of motion or returning him to work. In conclusion, there is not significant documentation to support evidence of the usage in this claimant and scientific evidence documenting the effectiveness is also not well established.

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 31st day of August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder