

IRO America Inc.

An Independent Review Organization

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September 13, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____
TWCC #: _____
MDR Tracking #: M2-05-2197-01
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 M.D., board certified and specialized in Pain Management. 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(s) including:

1. Notification of IRO assignment
2. Information provided by requestor
3. Information provided by respondent
4. Office notes by Dr. Mark Barhorst
5. Notes from "Center for Pain Recovery"

CLINICAL HISTORY

This patient sustained a work-related injury on ____, which has resulted in a chronic low back and radicular condition, primarily down the right side. The Patient has been treated with multiple modalities including physical therapy, medications including opioids, as well as epidural steroid injections and the use of a muscle stimulator device. The patient has had temporary benefit from the epidural steroid injections, and benefit from the muscle stimulator device has been documented by the patient and her treating physician, as well as the therapist at Center for Pain Recovery. In multiple incidents, there is mention made of muscle spasms as the component of her pain symptomatology.

DISPUTED SERVICE(S)

Under dispute is 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 appears that this patient has undergone multiple forms of therapy/treatment with only partial or temporary benefits. There seems to be concordant and various observers including the Patient herself and her physician, as well as her physical therapist that the use of the muscle stimulator device has benefited her and reduced her pain, specially for muscle spasms, etc. Though the documentation has not necessarily made it clear that this improvement from the device has resulted in reduction and usage of medications, increased physical functioning, etc., the Reviewer believe this to be a fairly safe presumption. Therefore, the Reviewer believes that long term/indefinite use of this stimulator device would be reasonable for this Patient.

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: [Claimant]

RS Medical/Mark Barhorst, M.D.

Attn: Joe Basham

Fax: 800-929-1930

Tomball Hospital Authority/F.O.L.

Attn: Katie Foster

Fax: 512-867-1733

Mark Barhorst, M.D.

Fax: 281-955-8508lo\

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 13th day of September, 2005.

Name and Signature of Ziroc Representative:

Sincerely,
ZRC Services Inc



Dr. Roger Glenn Brown
Chairman & CEO