

# MCMC

## IRO Medical Dispute Resolution M2 Prospective Medical Necessity IRO Decision Notification Letter

<b>Date:</b>	<b>07/26/2006</b>
<b>Injured Employee:</b>	
<b>Address:</b>	
<b>MDR #:</b>	<b>M2-06-1531-01</b>
<b>DWC #:</b>	
<b>MCMC Certification #:</b>	<b>IRO 5294</b>

### REQUESTED SERVICES:

Please review the item(s) in dispute: Pre-authorization denied for RS4i muscle stimulator.

### DECISION: **Upheld**

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IRO MCMCllc (MCMC) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO) to render a recommendation regarding the medical necessity of the above disputed service.

Please be advised that a MCMC Physician Advisor has determined that your request for an M2 Prospective Medical Dispute Resolution on 07/26/2006, concerning the medical necessity of the above referenced requested service, hereby finds the following:

RS4i stimulator is not medically necessary.

### CLINICAL HISTORY:

The injured individual is a 47 year old female with date of injury\_\_\_\_. The diagnosis is low back pain and radiculopathy. MRI showed a small disc protrusion at L5/S1. Electromyogram (EMG) showed an L5/S1 radiculopathy. She has had the RS stimulator since at least 01/2006. The injured individual had epidural steroid injections (ESIs) without help during this time frame. Her medications have not diminished nor is there any mention of the RS stimulator by any of her treating physicians.

### REFERENCES:

1. Journal of Pain. Oct 2001;2(5):295-300 "Electrical muscle stimulation as an adjunct to exercise therapy in the treatment of nonacute low back pain: a randomized trial." Glaser JA.

2. Am J of Pain Management. 1997;7:92-97 "Electrical Muscle Stimulation: portable electrotherapy for neck and low back pain: patient satisfaction and self-care." Wheeler, AH.
3. Clin Physiol. 2001;21:704-11 "The effect of three electrotherapeutic modalities upon peripheral nerve conduction and mechanical pain threshold" Alves-Guerro.
4. Ann Rheum Dis. 1999;58:530-40 "No effect of bipolar interferential electrotherapy and pulsed ultrasound for soft tissue shoulder disorders: a randomized controlled trial" van der Heijden et al.
5. Phys Ther. Oct 2001 81(10); "Philadelphia panel evidence based clinical practice guidelines on selected rehabilitation interventions for low back pain".
6. Clin Physiol Func Imaging. Sept 2002;22(5):339-47 Minder PM.
7. Arch Phys Med Rehab. Sept 2003;84(9):1387-94 Johnson MI.
8. ACOEM guidelines copyright 2004 pgs 48, 174, 203, 235, 300, 337, and 369.

**RATIONALE:**

The injured individual has had the unit six months with no response as based on her unchanging medications and the need for ongoing epidural steroid injections (ESIs) which also provided no relief. This treatment unit is also denied as it is an unproven treatment regimen with no more proven efficacy over a more simple and cost effective TENS unit.

Based on the literature, which does not document proven efficacy of this unit, it is denied due to a lack of necessity. Reference #1 states 50% of the patients in the study dropped out prior to completion, which questions the results of the study. Reference #2 states: "despite deficient support from sound research data..." which indicates studies on this are minimal. Reference #3 indicates interferential therapy is completely ineffective while reference #4 summarizes that it is comparable to a TENS unit at best. Reference #5 states: "No clinically important benefit of different frequency TENS treatment." Reference #6 states: "The application of interferential therapy had no overall beneficial effect on delayed muscle soreness." Finally, Reference #7 states: "Experimentally induced cold pain was not influenced by interferential treatment."

**RECORDS REVIEWED:**

- Notification of IRO Assignment dated 06/14/06
- MR-117 dated 06/14/06
- DWC-60
- MCMC: IRO Acknowledgment and Invoice Notification Letter dated 06/14/06
- MCMC: IRO Medical Dispute Resolution Prospective dated 07/10/06
- Texas Mutual: Letter dated 07/07/06 regarding transmittal of checks and records for review

- Texas Mutual: Letter dated 07/07/06 from LaTrece Giles, Sr. Medical Dispute Analyst
- Health & Medical Practice: Workers Compensation Prescription Forms (three) from Patrick McMeans, M.D.
- Texas Mutual: Letter dated 05/30/06 from Gay Green, Review Nurse
- Medical Progress Notes (handwritten) dated 05/26/06, 11/08/05
- Jerry M. Keepers, M.D.: Follow-Up Consultation Notes from John Sebok, D.O. dated 05/11/06
- RS Medical Prescription: Doctor's notes (handwritten) dated 04/28/06, 03/30/06, 01/24/06
- Texas Mutual: Letter dated 04/19/06 from Denise Carver, Review Nurse
- Jerry M. Keepers, M.D.: Initial Consultation Note dated 01/20/06
- Typed doctor's notes for the period 01/20/06 through 05/11/06 from Jerry Keepers, M.D. and Brian Buck, M.D.
- Typed doctor's notes for the period 08/01/05 through 01/04/06 with "Off Work Status" at top of pages
- Adult Patient Exam Form (handwritten) dated 07/14/05

The reviewing provider is a **Licensed/Boarded Pain Management/Anesthesiologist** and certifies that no known conflict of interest exists between the reviewing **Pain Management/Anesthesiologist** and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision prior to referral to the IRO. The reviewing physician is on DWC's Approved Doctor List.

### **Your Right To Appeal**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

This decision is deemed received by you 5 (five) days after it was mailed (28Tex.Admin. Code 102.4(h)(2) or 102.5(d)). A request for a hearing **and a copy of this decision** should be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
Texas Department of Insurance Division of Workers' Compensation  
P.O. Box 17787

Austin, Texas, 78744

Fax: 512-804-4011

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the 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 carrier, the requestor and claimant via facsimile or U. S. Postal Service from the office of the IRO on this**

**26<sup>th</sup> day of July 2006.**

**Signature of IRO Employee:** \_\_\_\_\_

**Printed Name of IRO Employee:** Beth Cucchi