

February 18, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0447-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel. This physician is board certified in occupational medicine, preventive medicine and public health. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns 26 year-old female who sustained a work related injury on ___. The patient reported that while at work she was helping transfer a patient into a wheelchair when she pulled her right shoulder causing immediate pain. The patient reported she felt pain in her shoulder, right side of her neck traveling down below her right shoulder blade. The patient had reportedly complained of tingling and numbness in her right hand and muscle spasms in her right trapezius muscle. The patient has been treated with a neuromuscular stimulator. The patient's diagnoses include muscle spasm and closed dislocation of her right shoulder.

Requested Services

Purchase of Neuromuscular stimulator.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

___ physician reviewer indicated that this patient sustained a work related injury to her back on ___. ___ physician reviewer also indicated that the documentation provided failed to show the patient's functional status, including range of motion and power. ___ physician reviewer noted that the patient has been treated with immobilization and with a neuromuscular stimulator. ___ physician reviewer also noted that the patient's pain level still appears to be significant even with the use of the neuromuscular stimulator. ___ physician reviewer indicated that there is

limited research available on the use of neuromuscular stimulators specific to the type of unit requested. ___ physician reviewer explained that there is no support of the use of a TENS unit in isolation for treatment of myofascial pain. ___ physician reviewer also explained that one of the most recent studies only mentioned the success of TENS in concert with other treatment. (Hou CR et al. Immediate effects of various physical therapeutic modalities on cervical myofascial pain and trigger-point sensitivity. Arch Phys Med Rehabilitation: 2002; 83(10): 1406-14). ___ physician reviewer further explained that it is important to integrate exercise with TENS treatment. ___ physician reviewer indicated that another study found that studies of various treatments, including TENS did not have support in the medical literature for treatment of myofascial pain syndrome beyond 4 weeks. (Fargas-Babjak A. Acupuncture, transcutaneous electrical nerve stimulation, and laser therapy in chronic pain. Clin J Pain 2001; 17)4 Suppl): 1105-13). ___ physician reviewer noted that there was no evidence submitted by the treating physician that supported the NT 2000 use above a traditional TENS unit. ___ physician reviewer explained that information available about the unit in question is limited. ___ physician reviewer indicated that it is unclear if the NT 2000 adds any benefit to traditional treatment for myofascial pain syndrome. Therefore, ___ physician consultant concluded that the requested neuromuscular stimulator is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

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)** days of your receipt of this decision. (20 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)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

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

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

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 18th day of February 2003.