

MDR Tracking Number: M2-03-1251-01
IRO Certificate# 5259

July 10, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Patient reports he experienced a low back injury at work on ___ and initially presented for medical care in ___ with a ___. He moved back to the ___ and began medical care with a ___. The patient then began seeing a chiropractor, ___, on 02/14/03. The patient appears to be diagnosed with lumbar sprain/strain and is treated with manipulation and multiple physical therapy modalities. Chiropractor also provides home exercises and stretches. MRI from 2/25/03 suggests L4/5 disc degeneration with HNP and facet hypertrophy. There is a 7mm anterolisthesis of L5 on S1 without posterior HNP. Neurodiagnostic reports suggest bilateral radiculopathy from L4/5 and L5/S1 levels. Chiropractic active and passive modalities are continued through 04/22/03 with little progressive improvement. Chiropractor provides patient with a RS41 interferential muscle stimulator on 4/22/03. This appears to be the primary item in dispute.

REQUESTED SERVICE (S)

Determine medical necessity for purchase of interferential muscle stimulator.

DECISION

The Interferential Muscle Stimulator appears to be a continuation of passive electrical modalities already provided in chiropractic office with little noted progressive improvement.

Medical necessity for continuing this modality for home use is not supported by the literature or by chiropractic documentation provided.

RATIONALE/BASIS FOR DECISION

There is no evidence in the literature supporting the use of Interferential Muscle Stimulators for the management of chronic pain or muscle pain and dysfunction beyond acute phase of care (Public Health Service, AHCPR Publication No. 95-0643).

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

If I can be of additional assistance regarding this case or file, please feel free to contact this office at your convenience.

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 (20 Tex. Admin. Code 142.5©)

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 148.3)

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

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party 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 11th day of July 2003.