

MDR Tracking Number: M2-03-1253-01
IRO Certificate# 5259

July 16, 2003

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. 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

This claimant is a 42-year-old male with complaints of back pain. The treating physician ___ diagnosed lumbosacral Neuritis, Lumbago and lumbar disc replacement. The claimant has been tested conservatively with medications, physical therapy and muscle stimulator.

REQUESTED SERVICE (S)

Purchase of interferential Muscle Stimulator

DECISION

Concur with pre-authorization determination

RATIONALE/BASIS FOR DECISION

There are no medical records to support the use of this device. While the treating physician advises the medical necessity of requested muscle stimulator, it is an investigational device and not within the prevailing standard of care for these types of injuries. A literature and Internet search noted several articles based on primarily antidotal evidence. There are no peer reviewed published studies that demonstrated the efficacy of this device.

With regard to the reasonableness of care, the science is simply not there to support the use of this experimental device. Therefore, the purchase of this device is not reasonable and necessary care and as physical examination the rule not to be approved at this is not the accepted standard of care.

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 17th day of July 2003.