

MDR Tracking Number: M2-03-1255-01
IRO Certificate# 5259

July 2, 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

The records indicate the patient was injured on ___ and has a diagnosis of intervertebral disc displacement without myelopathy lumbar region and chronic pain syndrome. There is a clinical note indicating increased pain since physical therapy discontinued, darvocet not functioning.

REQUESTED SERVICE (S)

Purchase of interferential muscle stimulator

DECISION

Deny request.

RATIONALE/BASIS FOR DECISION

The clinical records do not indicate that the device has either helped control pain, reduced utilization of medications, or other therapeutic services. There is limited research available regarding these devices that indicates they can be effective in controlling pain from muscular spasm in deconditioning. These devices appear to be most appropriate when they effectively reduce utilization of therapy services, reduce utilization of medications, or otherwise impact the individual in a way that helps them maintain their level of productivity.

There is no clinical information on this individual that would support any of these positive benefits. There is evidence that despite the use of the device, his pain is no longer controlled with his previous pain reliever, darvocet.

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 7th day of July 2003.