

MDR Tracking Number: M2-03-1259-01
IRO Certificate# 5259

July 23, 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

Claimant slipped and fell backwards while stepping onto some mats at work on ____. Reported injury to the left shoulder with a fracture of the greater tuberosity, and an RC injury/tear as well as neck pain and left knee pain. Had MRI of the neck and shoulder and EMG of arms, no radiculopathy, but bilateral CTS was noted on EMG. Fracture and subtle RC tear on shoulder MTI and DJD on Cervical MRI.

REQUESTED SERVICE (S)

Purchase RS muscle stimulator, 4 channel.

DECISION

Denial.

RATIONALE/BASIS FOR DECISION

No clinical information provided in physician's notes indicating device was ever noted to be of benefit, how it was being used and what effect, if any, it had on her pain control issues. The diagnosis' provided were of left shoulder fracture and Cervical DJD, and there is no obvious clinical indications for RS stimulator for these diagnosis'.

The only rationalization provided for purchase of this unit is in a letter of medical necessity; it is signed by ____, but not on his letterhead. That letter discusses the general benefits of muscle stimulators but provides no specific indication as to how this device is effective for this particular claimant.

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 23rd day of July 2003.