

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

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Austin, Texas 78738

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-03-1506-01
Name of Patient:	
Name of URA/Payer:	TML Intergovernmental Risk Pool
Name of Provider: (ER, Hospital, or Other Facility)	RS Medical
Name of Physician: (Treating or Requesting)	Larry Isbell, DC

July 29, 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 Texas Medical Foundation, 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

Medical Review of Texas (MRT) 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 MRT.

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Notice of Independent Review Determination  
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Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: RS Medical  
Larry Isbell, DC  
Texas Workers Compensation Commission

CLINICAL HISTORY

Patient diagnosed with lumbar disc disease and experiencing pain and muscle spasms.

REQUESTED SERVICE(S)

Interferential Muscle Stimulator (Home Unit)

DECISION

Approve purchase.

RATIONALE/BASIS FOR DECISION

Interferential muscle stimulation has been shown to relieve chronic pain, reduce muscle spasm, prevent disuse muscle atrophy, increase local blood circulation and help increase ranges of motion. Both therapies in both physical therapy and chiropractic.

Although the "Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Interventions for Low Back Pain" was given as the basis for disapproval, a review of that document indicates its findings were not represented properly.

First, the study makes no mention whatsoever of interferential – only electrical stimulation. Therefore, it is not germane to the question of medical necessity in regard to the item in question that supplies muscle stimulation and interferential.

Second, the study admits that others disagree with their conclusions by stating on page 1650, "In contract, both QTF (Quebec Task Force) and BMJ (British Medical Journal) recommended that rehabilitation

specialists use physical interventions at their own discretion to relieve spasm; reduce inflammation and pain; increase strength, ROM, and endurance; and improve functional status.” The use of this device for this patient meets those parameters in the discretion of the prescribing doctor.

And finally, the study only concluded (page 1661) that there was “a lack of evidence to include or exclude” electrical stimulation. In other words, no position was taken on wide array of beneficial modalities in this same category including “thermotherapy, therapeutic massage, EMG biofeedback, mechanical traction, therapeutic ultrasound, TENS, electrical stimulation, and combined rehabilitation interventions in the daily practice of physical rehabilitation.” Therefore, this study is not relevant to the medical necessity of this particular item.

A home unit for this patient is indicated since past usage has been beneficial, usage and compliance can be monitored by the physician and intensive treatment can be delivered in a more efficient and cost effective manner.

## 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 30<sup>th</sup> day of July, 2003.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell