

MDR Tracking Number: M2-03-1604-01  
IRO Certificate# 5259

August 27, 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

Documentation available from file suggests that this individual was injured at work on or about \_\_\_ as a result of a slip and fall. She presented to her chiropractor on 02/17/03 and was treated for lumbar neuritis and sacroiliac sprain/strain. The patient was given a lumbar support brace and provided with passive therapy consisting of mechanical traction, electric stimulation, and myofascial release. On 3/13/03 the patient was given an RS4i electric stimulator for home use in addition to continued therapy in the chiropractor's office. On 04/21/03, chiropractor requests continued use of muscle stimulator for an indefinite period in addition to chiropractic treatment and rehab. Medical necessity documents submitted by chiropractic appear to reference the study: "Electrical Muscle Stimulation as an Adjunct to Exercise Therapy in Treatment of Non-acute Low Back Pain" (Glaser, Baltz, Nietert, Bensen: Journal of Pain, Oct. 2001) as rationale for this request.

#### REQUESTED SERVICE (S)

**Determine medical necessity for proposed purchase of interferential muscle stimulator.**

Documentation submitted suggests that this device is similar to electric stimulation already provided in chiropractic office. This would appear to be a duplication of same or similar service. In addition, the reference study provided (Glaser et al. 2001) does not support use of muscle stimulator beyond 2 months duration.

No additional documentation can be found in available literature that supports long-term use of this device for either pain management or support of active rehabilitation. Finally, there is no evidence available suggesting that this device is any more effective for self-modulation than a common TENS unit.

#### DECISION

Available documentation does not support medial necessity for the purchase and indefinite use of this muscle stimulator device.

#### RATIONALE/BASIS FOR DECISION

Glaser et.al. JoP Oct. 2001, AHCPR Treatment Guidelines, GCQAPP Mercy Center Consensus Conference, 1990/1992 RAND Consensus Panel]

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.

#### 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 29<sup>th</sup> day of August 2003.