

September 3, 2003

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744-1609

MDR Tracking # M2-03-1723-01  
IRO # 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

This patient was injured in the spine on the job when a driller engaged accidentally and struck some toungees that were attached, which in turn struck the patient, knocking him to the ground. He has been prescribed a muscle stimulator for the pain. The treating doctor, \_\_\_, recommended an interferential muscle stimulator. Peer reviews performed by \_\_\_, and \_\_\_ denied the unit due to a lack of medical necessity. The treating doctor stated that he felt that the unit was medically necessary despite the fact that the patient is pending surgical intervention. What is unclear by the documentation is exactly where the injury is located in the patient's body. There is some question as to whether the injury is cervical, lumbar or both.

#### REQUESTED SERVICE

The purchase of an interferential muscle stimulator is requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

There is no documentation that would indicate the medical necessity of this device. Specifically, if the patient is surgical as indicated by the treating doctor, this stimulator would not be indicated. Also, the chronic nature of this case would make this care inappropriate. Please note that interferential is a passive treatment that has minimal effect on a patient such as this and would not

lead to improvement in the patient's condition. As a result, I do not believe that this care is a reasonable alternative for this patient at this point in time.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to 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 (28 Tex. Admin. Code 142.5(c)).

**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 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 3<sup>rd</sup> day of September 2003.**