

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-04-0817.M2**

**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

MDR Tracking Number: M2-03-1741-01

September 15, 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 \_\_\_.

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**CLINICAL HISTORY**

Information made available for this review includes an initial request for two month rental of the unit signed by \_\_\_ dated 4/23/03, a letter of medical necessity signed by \_\_\_ for the purchase of the unit dated 6/11/03. The patient was diagnosed with lumbosacral neuritis and the purpose of the purchase was to decrease spasm and pain, prevent atrophy, increase range of motion and enhancement of blood circulation. \_\_\_ pointed out that the unit requires eight pads per month and that the unit is not a TENS unit.

A preauthorization request for the purchase of the RS-4-I stimulation unit at \$2,495 dated 6/30/03. Included with the request is a study from the Journal of Pain indicating patients who used the unit over the first two months of a six month program had better results than those who did not use the unit. The study also showed that the patients continued to feel a benefit from the unit after

discontinuation of the unit. The report was published in the Journal of Pain, Volume Two, Number 5, October 2001, Pages 295-300.

Also made available was an initial denial of preauthorization signed by \_\_\_ of \_\_\_. The rationale was stated as the proposed device is not broadly accepted as the prevailing standard of care and is not recommended as medically necessary. Such passive modalities are only indicated in acute phase of treatment and their use must be time limited. The Philadelphia Panel Physical Therapy Study had little or no supporting evidence to include such modalities in the treatment of chronic pain greater than six weeks. The denial was appealed on 7/8/03 and again denied by \_\_\_.

There was a Medical Dispute Resolution request signed by \_\_\_, Denial Desk Manager of \_\_\_ on 8/15/03, and on 8/29/03 a documentation packet documenting medical necessity included the initial request for the rental, the request for the purchase, and a daily log of the patient's use of the stimulation unit, which appears to be generated by the unit itself. It appears that over the initial treatment period starting 4/23/03 and ending 6/30/03, the patient used the unit one to two times daily, two to four times weekly.

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Finally, a National Coverage Determination Report for Neuromuscular Electrical Stimulation Units was evaluated. This report was prepared by the \_\_\_ and the effective and implementation date of the report was 4/1/03. This report, which will be discussed later in this report, indicates that the two uses for a neuromuscular electrical stimulation unit is to treat muscle atrophy or to enhance functional activity of neurologically impaired patients after a spinal cord injury. It appears that \_\_\_ feels that this unit is medically necessary due to muscle atrophy and not a spinal cord injury

#### REQUESTED SERVICE(S)

Purchase of the RS-4-I electrical stimulation unit.

#### DECISION

Based upon documentation made available for this review and research regarding this type of treatment, the purchase of the unit is not reasonable and medically necessary for this patient.

#### RATIONALE/BASIS FOR DECISION

The rationale for this decision is based upon three different sources. The first is the source utilized by Drs. Garcia and Buck, the Philadelphia Panel Physical Therapy Study, which does seem to indicate that electrical muscle stimulation is a passive modality and the study does not lend evidence to ongoing benefit from this type of treatment after the initial six weeks.

The second criterion for the denial is the National Coverage Determination Report from the Centers for Medicare and Medicaid. The documentation is quite specific, indicating that the two purposes for such a unit is the treatment of muscle atrophy or to enhance functional activity in neurologically impaired patients. There is nothing in the documentation to suggest that the patient has a spinal cord injury. He has been diagnosed with lumbar radiculitis, which indicates irritation of a nerve root and not a spinal cord injury. While muscle atrophy is one of the criteria listed in the letters of medical necessity from \_\_\_ and \_\_\_, they also discuss pain control and the alleviation of muscle spasm, increased range of motion and increased blood flow to the area. Medical documentation made available for this review does not illustrate evidence of muscle atrophy in this case and in fact, all documentation, including questionnaires filled out by the patient seems to indicate that the unit is being used primarily for pain control. With regards to the treatment of muscle atrophy, the National Coverage Determination report does mention specific criteria, "Coverage of NMES to treat muscle atrophy is limited to the treatment of patients with disuse atrophy where the nerve supply to the muscle is intact including brain, spinal cord and peripheral nerves and other non-neurological reasons for disuse atrophy. Examples include casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery." There is nothing in the medical records to indicate the patient has undergone any type of surgical intervention or is expected to require surgical intervention, nor is there any specific documentation relating to the extent of disuse atrophy.

The last criteria utilized for the denial for the purchase of this unit is in fact the report supplied by \_\_\_ with regards to the study from the Journal of Pain. While the study does suggest that patients do appear to improve with physical rehabilitation in conjunction with the use of the neuromuscular electrical stimulation unit, the study does indicate that the use of the unit was discontinued after two months and the patient did continue to improve with decreased symptomatology and increased function. It appears at this point that the patient had undergone two months of use of the equipment, which is somewhat in line with the Philadelphia Panel study. Based upon documentation made available for this review, renting of this equipment may have been medically necessary but there is nothing to suggest that the purchase for indefinite use is medically reasonable or necessary for this patient.

### **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 16<sup>th</sup> day of September 2003.