

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-03-1816-01

September 15, 2003

An independent review of the above-referenced case has been completed by a doctor board certified in family practice. 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

___ sustained a work related injury on ____. The earliest available records are from ___ on 4/7/03 with notations of neck and right arm pain and myofascial pain. A note is made about an MRI scan of the spine but no results were forwarded. A prescription to request a muscle stimulator notes the patient had medications, physical therapy and surgery, but no documentation was enclosed. A follow-up note and form letter requesting the purchase of a muscle stimulator was written on 6/11/03.

REQUESTED SERVICE(S)

Purchase of an Inferential Muscle Stimulator.

DECISION

Uphold denial.

RATIONALE/BASIS FOR DECISION

Due to the paucity of medical records, the exact course of treatment and diagnosis of this patient's injury is unclear, but the general diagnosis of right arm

and neck pain is noted. There is no documentation supporting the diagnosis of RSD. Either way, the patient still has pain longer than 8 months after his original injury which would make his symptoms chronic in nature as he still requires multiple medications for relief. There is no peer reviewed literature or general consent in the medical community to support the use of this device for chronic arm and neck pain. Therefore, the purchase of this device for indefinite use is not medically necessary, so the denial is upheld.

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 16th day of September 2003.