

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-03-1817-01

October 13, 2003

An independent review of the above-referenced case has been completed by a medical physician 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 \_\_\_.

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### CLINICAL HISTORY

This patient sustained a work related injury on \_\_\_\_. He failed conservative treatment and underwent endoscopic discectomy on 12/9/02. He continued to have symptomology and underwent a fusion on 6/16/03. He had been treated with medications, therapy, a lumbar binder, epidural steroid injections, and a muscle stimulator.

### REQUESTED SERVICE(S)

Purchase of an Interferential Muscle Stimulator.

### DECISION

Uphold previous denial.

### RATIONALE/BASIS FOR DECISION

This patient sustained a work related back injury on \_\_\_\_ and failed conservative treatment and had an endoscopic discectomy on 12/9/02. No objective evidence is submitted to substantiate any decrease in medications, increase in

functionality, or other parameters with the use of the muscle stimulator. This device is used as an adjunctive therapy in the acute phase of treatment. This view is considered the standard of care and supported by generally accepted guidelines including the Philadelphia Panel Study and CMS guidelines. There is no peer review, double-blinded studies or literature to support the use of this device in a chronic pain patient after a diskectomy. Therefore, the prior 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 14<sup>th</sup> day of October 2003.