

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-03-1818-01

October 6, 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 ___.

Notice of Independent Review Determination

CLINICAL HISTORY

This patient sustained a work related injury on ____. Apparently, the patient had treatment involving physical therapy, hot packs and medications. A muscle stimulator was requested on 3/26/03 for 2 months of use. Subsequently, this device was requested for purchase.

REQUESTED SERVICE(S)

Purchase of an interferential muscle stimulator.

DECISION

Uphold prior denial.

RATIONALE/BASIS FOR DECISION

This patient sustained a work related injury to his left shoulder on ____. A prescription for a muscle stimulator on 3/26/03 noted his diagnosis as left shoulder pain and chronic muscle spasms. There is no objective documentation to support the medical necessity of this device for this patient at this stage of his injury. The requested device is to be used as adjunctive therapy in the acute

phase of an injury. This is standard of care and supported by the Philadelphia Panel Study and the Center for Medicare and Medicaid guidelines. No double-blinded, peer review literature or generally accepted guidelines support the use of this type of device for chronic pain patients. Therefore, the prior denial for purchase of this device 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 7th day of October 2003.