

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-03-1822-01

October 20, 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

\_\_\_\_ 33-year-old male, sustained an on-the-job injury while working as a "hydroblaster" for \_\_\_\_\_. Apparently he was moving a water hose when a large metal shield fell, striking him on the head and shoulder and pinning him against a beam. He was taken to the ER, x-rayed (lumbar: normal, left shoulder: A/C joint narrowing suggestive of early DJD) and sent home with medication. He then presented to \_\_\_\_, a chiropractor, on 7/12/03 and was diagnosed with cervical, lumbar and shoulder sprain/strain, along with radiculitis. A comprehensive conservative treatment regime was instituted which included manipulation/mobilization, adjunctive physiotherapeutic modalities, therapeutic exercises, progressing to work conditioning and hardening then chronic pain management. MRI scans of the cervical and lumbar spine areas were obtained on 8/8/03. Lumbar spine was normal, cervical spine showed a small central and left paracentral disk herniation at C6/C7. MRI scan of the left shoulder was obtained 8/18/03 and was read as normal. Electrodiagnostic studies were performed on 9/17/03 and EMG was read as negative for radiculopathy. He has had a few independent evaluations: Pain management consult (\_\_\_\_, MD) on 3/13/03 determined lumbar vertebrogenic pain and cervical strain with radiculitis and recommended ESI trial. Designated Doctor evaluation (\_\_\_\_, MD 3/17/03) determined continuing left arm and neck pain, agreed with recommended ESI's. He did not believe the patient was at MMI,

projected MMI July 2003. The patient apparently did not receive this treatment, continued with \_\_\_ on a monthly basis between April and July 2003 for “maintenance and observation.”

A prescription for an interferential muscle stimulator purchase was written by \_\_\_ on 3/13/02. This has been denied for payment based on medical necessity and is thus referred for medical dispute.

#### REQUESTED SERVICE(S)

Medical necessity of purchase of an interferential muscle stimulator.

#### DECISION

Deny. There is no establishment of medical necessity for the purchase of an interferential muscle stimulator for this patient.

#### RATIONALE/BASIS FOR DECISION

While there is not a determination of MMI or impairment in the records, it appears that the patient is at a stationary clinical platform, as the records demonstrated very little change in the patient’s subjective and objective presentation. The documentation does demonstrate that the patient continues with a pain level of between 5-6/10, with continued clinical evidence of muscle tenderness, hypertonicity of the cervical and left shoulder areas.

A trial of care has been documented with a rental period, this form of therapy has been employed with success in the patients care regime and therefore appears to be appropriate for home use.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such information may or may not change the opinions rendered in this evaluation.

#### **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 21<sup>st</sup> day of October 2003.