

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0073-01

October 8, 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

Documentation available from the file suggests that this individual was injured at work on or about ____ as a result of flipping a mattress. On 7/16/03, his treating chiropractor, ____, prescribes a RS4I electrical stimulator for indefinite use. The patient was seen for pain management evaluations on 6/11/03, 6/25/03 and 7/8/03 with ____ and no mention of this device or its necessity was made in these reports. Designated doctor exam performed 5/22/03 finds the patient at maximum medical improvement with 0% impairment for back conditions. Chiropractic does provide some supporting documentation supplied by RS4I manufacturer, ____, citing a study by ____ et al. published in the Journal of Pain, October 2001. A patient progress report submitted by ____ on 7/16/03 suggests that the patient, himself, indicates that he can see little benefit from continued use of the device.

REQUESTED SERVICE(S)

Determine medical necessity for proposed purchase of RS4I sequential 4-channel electric muscle stimulator unit.

DECISION

Available documentation does not support medical necessity for the purchase and indefinite use of this muscle stimulator device.

RATIONALE/BASIS FOR DECISION

Documentation submitted suggests that this device is similar to electric stimulation already provided in chiropractic office. This would appear to be a duplication of same or similar service. In addition, the reference study provided (Glaser et al. 2001) does not support use of muscle stimulator beyond 2 months duration. No additional documentation can be found in available literature that supports long-term use of this device for either pain management or support of active rehabilitation. Finally, there is no evidence available suggesting that this device is any more effective for self-modulation of pain than a common TENS unit.

[Glaser et al. JoP Oct. 2001, AHCP Treatment Guidelines, GCQAPP Mercy Center Consensus Conference, 1990/1992 RAND Consensus Panel]

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.

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 10th day of October 2003.