

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-1176.M2

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0079-01

October 14, 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 due to a MVA on ____. She underwent a very thorough evaluation that included radiographs, MRI, CT, myelogram, and electrodiagnostic studies. She had extensive treatment modalities that consisted of medications, epidural steroid injections, aqua therapy, physical therapy, biofeedback, and a pain program. Her injury was complicated by significant psychiatric issues including depression, anxiety, a son who died of AIDS, and her husband who had a "nervous breakdown." Also noted were a return to work note on 5/8/94 and one on 5/11/94 with light duty restrictions. Apparently, an MMI was done on 2/12/95 with an impairment rating of 7% and one on 4/9/95 of 10%. An IME performed on 10/11/00 found no further treatment was indicated and a recommendation to return to work immediately at medium duty level.

REQUESTED SERVICE(S)

Purchase of an Interferential Muscle Stimulator.

DECISION

Uphold prior denial.

RATIONALE/BASIS FOR DECISION

All documentation was thoroughly reviewed. This patient sustained a cervical injury in a work related MVA on _____. Unfortunately, this patient did not respond to extensive treatment and became a chronic pain patient. The requested device is accepted as an adjunctive therapy in the acute phase of treatment. This is standard of care and supported by accepted guidelines and studies such as the Philadelphia Panel Study, CMS and N.A.S.S. guidelines. No peer review, double-blinded studies are available to substantiate the use of a muscle stimulator in chronic pain patients with cervical injuries. Also, no documentation is submitted to show objective evidence of efficacy of the muscle stimulator such as increase function, improvement in work status, decrease in medication use, or decrease in other therapies or modalities. For these reasons, the medical necessity for this device is not support, so 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 16th day of October 2003.