

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** November 14, 2003

**RE: MDR Tracking #:** M2-04-0163-01  
**IRO Certificate #:** 5242

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery and has an ADL Level 2. The Orthopedic Surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### **Clinical History**

The claimant has a history of chronic back pain allegedly related to a compensable work injury of \_\_\_.

### **Requested Service(s)**

Purchase of interferential and muscle stimulator unit

### **Decision**

I agree with the insurance carrier that the requested intervention is not medically necessary.

### **Rationale/Basis for Decision**

Generally long term use of stimulators is appropriate when there has been at least a 2 month trial to determine effectiveness in significantly increasing objective parameters such as range of motion, decrease in the use of pain medication, increase in functional capacity, and a decrease in the need for use of other medical services. The claimant was prescribed an interferential stimulator unit on 3/17/03. According to the treatment plan on the prescription, the indications included maintaining or increasing range of motion and preventing or retarding disuse atrophy. There is no objective documentation of muscle circumference or strength prior to onset of use, nor is there documentation of any measurement of range of motion to indicate adherence to the treatment plan on the prescription. There is no documentation of these objective parameters after onset of use to indicate any significant benefit from the use of the device.

There is no documentation of exhaustion of conservative measures of treatment including bracing and physical therapy (McKenzie spinal stabilization). Controlled studies indicate interferential stimulation and TENS have no significant effect on nociceptive response (Arch Phys Med Rehabil. 2000 Mar, 81(3): 324-33). Due to inadequate documentation and a lack of support in peer reviewed literature for its use, the requested durable medical equipment is not deemed to be reasonable or medically necessary in this clinical setting.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to 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 (28 Tex. Admin. Code 142.5(c)).

**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 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.