

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0217-01
IRO Certificate Number: 5259

October 27, 2003

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, 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 ___.

Sincerely,

CLINICAL HISTORY

Claimant was working as a schoolteacher when she tripped over a child, landing on her right shoulder on ____. She had a constant right shoulder pain since that time and has received surgical procedure. Post surgically her pain continued and she received botulism injections for muscle spasm in the right shoulder muscles.

REQUESTED SERVICE(S)

RS Muscle Stimulator Purchase

DECISION

Agree with carrier's adverse determination. Do Not Approve Purchase.

RATIONALE/BASIS FOR DECISION

The clinical information provided by the treating physician does not support a direct benefit of this device for this particular patient. There is a letter from ____, which appears to be a preprinted letter, as it does not contain any specific clinical data about this patient, or this patient's response to use of this particular device. There is no indication as to how this device reduced pain medication, increased employability, or otherwise had a positive impact on this specific patient. Without specific clinical data about this patient's response to this device there is no reasonable medical need for purchase of this device as it relates to the work-related injury of ____.

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 28th day of October 2003.