NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0425-01
IRO Certificate No.: 5259

December 16, 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 ___.

CLINICAL HISTORY
___ sustained a work related shoulder injury on ___. He had extensive treatments including medications, physical therapy, two surgical procedures, a muscle stimulator, and injection therapy of the shoulder joint and biceps tendon. Of note is that progress notes on 7/7/03 and 9/27/03 state a date of injury of ___.

REQUESTED SERVICE(S)
Purchase of an interferential muscle stimulator.

DECISION
Uphold previous denial.

RATIONALE/BASIS FOR DECISION
Little objective documentation is presented to substantiate the effectiveness of the muscle stimulator such as patient stimulator usage log, pharmacy records, physical therapy records, changes in work status, or MMI evaluations. Also, this device is generally accepted to be used as an adjunctive treatment in the acute phase of treatment.

This viewpoint is standard of care and supported by generally accepted guidelines and standards such as N.A.S.S., CMS, and the Philadelphia Panel Study. No large scale, double-blinded studies are available to prove that this type of device is effective for the treatment of chronic pain in a patient who has had shoulder surgery. For these reasons, the muscle stimulator is denied for this patient.

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 December 2003.