**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

MDR Tracking Number: M2-04-0591-01
IRO Certificate No.: 5259

December 29, 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
This patient sustained multiple work related injuries on ___. She had exhaustive conservative treatment including medications, physical therapy, injection therapy, work restrictions, and a muscle stimulator. She received at least 2 rounds of Myobloc injections. She eventually had an IDET procedure. Submitted records indicate excellent compliance with the muscle stimulator and physical therapy sessions. Unfortunately, she continued to have pain symptoms and a muscle stimulator was ordered on 8/14/03 to manage her chronic pain. This request was denied as was an appeal to purchase this device.

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

DECISION
Uphold prior denial.

RATIONALE/BASIS FOR DECISION

As noted in the submitted records, this patient has persistent, chronic pain after extensive conservative and surgical treatment. This device is used as an adjunctive therapy in the acute phase of treatment. This view is standard of care and supported by CMS, N.A.S.S., and the Philadelphia Panel Study. No accepted double-blinded, placebo controlled studies are available to support the use of this type of device in the treatment of chronic, post-surgical pain patients. Therefore, prior denials for purchase of this item are 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 29th day of December 2003.