

MDR Tracking Number: M2-04-0593-01

May 25, 2004  
IRO Certificate# 5259

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

44 pages of records are submitted for review including insurance company correspondence with denial letters, muscle stimulator prescriptions, patient self report form and usage log, an attorney letter, a review and denial by \_\_\_\_, a physician progress note dated 10/13/03 as well as radiograph reports.

\_\_\_\_ was apparently injured on \_\_\_\_\_. She received physical therapy, medications, and a muscle stimulator. No reports are submitted of the original injury, evaluation, and treatment. No therapy notes were enclosed. Only progress notes from \_\_\_\_\_ dated 10/13/03 was noted.

REQUESTED SERVICE (S)

Purchase of an IF muscle stimulator

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Insufficient objective, clinical evidence is submitted to warrant the purchase of this device. In fact, a patient usage log shows she used the muscle stimulator on 11 days out of 29 days in September. This type of device is typically used as adjunctive therapy in the acute phase of treatment. This view is standard of care and supported by C.M.S. and NASS guidelines, peer-review literature, and the Philadelphia Panel Study. Therefore, since this patient now has chronic pain and the submitted records are insufficient to justify continued use of this device, 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 27<sup>th</sup> day of May 2004.