

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0637-01
IRO Certificate Number: 5259

January 13, 2004

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 back injury at work on ____. She was extensively treated with medications, chiropractic treatment, multiple injections, physical therapy, and a muscle stimulator. Her latest designated doctor evaluation on 12/5/03 projected her to reach her MMI on 2/1/04. A request to purchase a muscle stimulator was denied and an appeal upheld the denial.

REQUESTED SERVICE(S)

Purchase of an interferential muscle stimulator.

DECISION

Uphold prior denial.

RATIONALE/BASIS FOR DECISION

___ sustained her injury on ___ and her symptoms persisted through the time of this review after multiple and extensive conservative treatments. She is now categorized as a chronic pain patient.

The requested device is typically used as an adjunctive treatment in the acute phase of treatment. This view is supported by accepted guidelines and literature such as CMS, N.A.S.S., and the Philadelphia Panel Study. No double-blinded, peer reviewed studies support the use of muscle stimulators for chronic back pain patients. Therefore, the reviewed medical records do not support the purchase of this device so 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 14th day of January 2004.