

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0780-01
IRO Certificate No.: 5259

February 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

This is a gentleman who sustained a lumbar injury. Initially treated conservatively, this advanced up through a lumbar surgery. There are continued complaints of pain. An RS4i stimulator has been requested well after the date of surgery.

REQUESTED SERVICE (S)

Proposed purchase of interferential muscle stimulator.

DECISION

Endorse the pre-determination of a non-approval.

RATIONALE/BASIS FOR DECISION

The primary treating physician failed to produce any competent, objective, and independently confirmable medical evidence demonstrating the efficacy of this device. The utilization curve is documented; however there is no measurable improvement in this condition. Has the use of oral analgesic been reduced? There is no data to indicate that is the case. Clearly there is no established positive result from this use of this device. Even the anecdotal evidence is marginal relative to efficacy. Moreover, there is no clinical assessment made by the primary treating physician that would support the use let alone the purchase of this device. Lastly, this is a passive device and noting the date of injury, this claimant should be doing only those active modalities that enhance the rehabilitation of this injury. The proposed device is not broadly accepted as the

prevailing standard of care and is not recommended as medically necessary. Such passive modalities are indicated in the acute phase of care and their use must be time-limited.

The Philadelphia Panel Physical Therapy Study found little or no supporting evidence to include such modalities in the treatment of chronic pain greater than 6 weeks. Moreover, the efficacy of this type of device in the long-term patient has been studied repeatedly. As noted by Herman (Spine 1994 Mar 1; 19(5): 561) this treatment adds no apparent benefit. Lastly as described by Deyo (NEJM 1990 Jun 7(23): 127-34) TENS is no more effective than placebo. The literature of blinded peer-reviewed studies does not support the efficacy of this device. The one study that was completed had a drop out rate of more than 50%, the appropriate methodologies were not reported and the overall efficacy was not a function of the device rather other external factors. This device does not improve the situation, there is no identification of a decrease in medication use and the functionality of the claimant was not reported out. The pathology is in the disc; the current talked about does not reach the level of the pathology. Lastly, the progress notes of the primary treating physician indicate a well healed wound and the surgical intent was reached. There is no discussion in the progress notes of the use of this device only the boilerplate vendor distributed document. The primary treating physician offers no clinical indication for the use of this device.

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 17th day of February 2004.