

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0816-01

March 8, 2004

IRO Certificate# 5259

An independent review of the above-referenced case has been completed by a medical physician. 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

Forty-one year old male with date of injury ___, to his lower back (apparently had a back operation in 1987). The diagnosis in 1995 was left lumbar radiculitis. This patient has received extensive physical therapies and numerous opioid trial-most currently on Duragesic 100 mcg per hour. Treatment also includes consideration for a morphine pump and further surgeries. In addition, ___, details multiple neurologic problems.

REQUESTED SERVICE (S)

Intereferential and muscle stimulator

DECISION

Uphold denial.

RATIONALE/BASIS FOR DECISION

Considering this patient's history and peer-reviewed literature, uphold denial. According to Dr. R.E. Windsor et al in 1993, the treatment guidelines outlined Dr. Jeffrey L. Young in the *Low Back Pain Handbook*, 1997, the Quebec Task Force, *Supplement to Spine*, 1997, and Drs. D. Weber and R. Browne in Dr. Braddon's textbook *Physical Medicine and Rehabilitation*, therapeutic electricity, including electrical stimulation, is best used during the acute phase of rehabilitation. Electrical therapies are considered adjunctive treatments, rather than primary curative interventions.

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 9th day of March 2004.