

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0832-01
IRO Certificate No.: 5259

February 24, 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

Apparently this patient had a work related back injury on ___. In the summer of 2003, she underwent a PLIF procedure. She continued to have pain post-operatively. The clinical records submitted were primarily for the post-operative outpatient care.

REQUESTED SERVICE (S)

Purchase of an interferential muscle stimulator

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Although detailed clinical notes were not available prior to 8/26/03, the fact that her original injury was in ___ supports the fact that this patient is now a chronic pain patient. ___ note on 10/21/03 notes this patient has chronic, neuropathic pain probably prior to her surgery. Standard of care and accepted clinical ‘

guidelines and literature do not support the use of muscle stimulator devices for chronic conditions.

Generally, these devices are used in the acute phase of treatment. No extraordinary circumstances or response is supported in the submitted records to substantiate the purchase of this device for perpetual use. Therefore, the requested service is denied.

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 25th day of February 2004.