

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0994-01

March 30, 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

___ sustained a work related neck injury on ___. She apparently was treated with physical therapy, medications, and a muscle stimulator. A FCE was done on 8/29/03 and she was released to work. Submitted was a form letter from the treating physician and a letter from the patient describing subjective improvement with the muscle stimulator.

REQUESTED SERVICE (S)

Purchase of an interferential muscle stimulator

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

This device is generally used as an adjunctive therapy in the acute phase of treatment. This view is supported by peer review literature, standard text books, accepted guidelines and general standard of care.

Please reference CMS guidelines, N.A.S.S. position paper on this device, as well as the Philadelphia Panel Study.

No scientific evidence is available to support its use in patients with chronic pain. Also, the enclosed records do not reflect any objective evidence on the effectiveness of this device or any extraordinary circumstances in this case to justify the purchase of an interferential muscle stimulator for this patient. Therefore, 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 1st day of April 2004.