

MDR Tracking Number: M2-04-1101-01  
IRO Certificate # 5259

April 14, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in family medicine. 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 back injury on \_\_\_\_. Treatments included medications, analgesic creams, multiple courses of physical therapy, facet injections, radiofrequency neurotomies, an anterior fusion in 1998 and a posterior fusion in May of 2002. A muscle stimulator was ordered on 9/9/03 and requested for purchase on 12/3/03.

#### REQUESTED SERVICE (S)

Purchase of and interferential muscle stimulator.

#### DECISION

Denied.

#### RATIONALE/BASIS FOR DECISION

\_\_\_ had extensive treatments for a work related back injury including 2 surgical procedures. One of these treatments was an interferential muscle stimulator, which was initially recommended over \_\_\_ after his original injury and over one year after his second surgery. This type of device is generally used as an adjunctive therapy in the acute phase of treatment. No accepted peer-review literature supports its use for post surgical patients with chronic back pain.

This view is supported by CMS and NASS guidelines and the Philadelphia Panel Study. No objective evidence is submitted to prove the efficacy of this device or any extraordinary circumstances present to justify the purchase and long term use of this device. Therefore, the decision to deny the purchase of a muscle stimulator 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 16<sup>th</sup> day of April 2004.