

MDR Tracking Number: M2-04-1107-01  
IRO Certificate # 5259

April 20, 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

\_\_\_ sustained a work related back injury on \_\_\_\_. Apparently, she was treated with medications, physical therapy, facet injections, a home exercise program, a work hardening program, and an IF muscle stimulator. Records were submitted concerning a corneal laceration from 2001 through 2003 that appear unrelated to the injuries sustained on \_\_\_\_.

#### REQUESTED SERVICE (S)

Purchase of an IF muscle stimulator

#### DECISION

Denied.

#### RATIONALE/BASIS FOR DECISION

Although two stimulator evaluations dated 12/10/03 and 2/16/04 state the patient had a 50% subjective reduction in pain, the original pain level persisted as an 8 on a 1-10 scale. Furthermore, no objective evidence was submitted to document a decrease in services, medications, or an increase in job function strictly due to the efficacy of this device.

In general, this device is used as an adjunctive therapy in the acute phase of treatment. No peer review literature exists to support its use in chronic pain patients. This view is supported by CMS guidelines, NASS position paper, and the Philadelphia Panel Study.

For the above reasons, the request to purchase this device 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 21<sup>st</sup> day of April 2004.