

MDR Tracking: M2-04-1129-01
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 multiple injuries from a fall at work on ____. She was treated with various modalities including medications, joint injection, physical therapy, biofreeze, bioflex cream and a surgical procedure on 11/15/03. A prescription for an interferential muscle stimulator was ordered on 11/24/03, and the request to purchase this device was dated 1/22/04.

REQUESTED SERVICE (S)

To purchase an interferential muscle stimulator

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

This type of device is generally used in the acute phase of treatment. This view is consistent with CMS and NASS guidelines, the Philadelphia Panel Study, and peer reviewed literature. No conclusive evidence exists to justify its use on a patient who is status post shoulder surgery. Also, the submitted records do not contain objective evidence of the muscle stimulator's effectiveness in this patient nor do they reveal an extraordinary circumstances to support the purchase of this device.

For these reasons, the requested purchase 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 15th day of April 2004.