MDR Tracking Number: M2-04-1175-01
IRO Certificate # 5259

May 13, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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

___, a 47-year-old female, sustained injuries to both knees as a result of a fall while on the job working as a fruit packer. She slipped on some fruit and landed one leg out front, the other out behind. She subsequently underwent two separate arthroscopic debridements, one to each knee, with partial meniscectomy on the right. Significant degenerative chondromalacic changes were noted, especially on the right. The patient subsequently underwent a rehab program, but continued with pain, particularly with respect to the right knee, which included swelling. She was placed at MMI on 04/06/02 with a 4% impairment related to the right knee. Her treating doctor currently appears to be ___ a chiropractor. I do not have any records of his treatment aside from prescription. He wrote a prescription for an RS4i muscle stimulator in November 2003. This was then used by the patient for the subsequent two months. A note dated 1/16/04 from ___ indicates a "30% reduction" in "movement and pain and function". Unfortunately there is no evidence supplied to support this statement. There is evidence for the use of the stimulator by the patient provided in the documentation.

REQUESTED SERVICE (S)

Medical necessity for purchase of a muscle stimulator

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
The patient is at a stationary clinical platform, with ongoing functional and symptomatic complaints. The documentation unfortunately does not demonstrate any degree of objective improvement with the use of the stimulator in the form of increased function, reduced pain or reduction in medication or treatment dependence. The only submission is a log of an unvarying pattern of stimulator usage, and an unsubstantiated impression of improvement, without even a pain diagram to rely upon.

The current standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits), is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

The provided documentation does not demonstrate that the above standard of medical necessity has adequately been met in this particular case.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

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 14th day of May 2004.