

June 14, 2004

MDR #: M2-04-1358-01  
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Anesthesiology and Pain Management and is currently listed on the TWCC Approved Doctor List.

### **REVIEWER'S REPORT**

#### **Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: letter of medical necessity, office notes and physical therapy notes.

Information provided by Respondent: correspondence.

#### **Clinical History:**

There is no medical history provided regarding this claimant's injury other than documentation by physician advisors that the claimant sustained a soft tissue injury to the neck and right shoulder region. The treating doctor did not provide any medical records regarding history or physical or subsequent progress notes regarding this claimant's clinical condition or progress. The only documents provided for review are the usage logs from the DME in question.

#### **Disputed Services:**

Purchase of a muscle stimulator

**Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that a muscle stimulator is not medically necessary in this case.

**Rationale:**

Based on the records provided for review, this claimant has no clinical condition for which the use of this muscle stimulator device is medically indicated, reasonable, or necessary. Moreover, there is no documentation of clinical benefit, objective improvement, therapeutic gain, improvement in functional clinical status, or for that matter, any clinical benefit whatsoever for the use of this machine. The letter of medical necessity is a form letter provided by the DME manufacturer for the use of its providers.

The only valid medical study that has been performed regarding this stimulator unit involved its adjunctive use for treatment of lumbar pain for no more than 2 months, along with active exercise. There is, therefore, no valid peer-reviewed medical study demonstrating either short or long-term efficacy for the use of this device for treatment of neck or right shoulder pain. Moreover, none of the information tabulated in the usage logs provides any indication of whether this claimant had any pain relief or functional improvement despite over 4 months of rental of the device. Purchase of the device does not meet standard of care, medical reasonableness, or medical necessity, therefore is not appropriate.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_\_ is deemed to be a Commission decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3)

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission, MS-48  
7551 Metro Center Dr., Ste. 100  
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

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 June 14, 2004.

Sincerely,