

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-1381-01
IRO Certificate Number: 5259

July 14, 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 Texas Medical Foundation, 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 ___.

Sincerely,

CLINICAL HISTORY

Patient is 31-year-old male painter and sandblaster who, on ___, was sitting with both legs extended eating his lunch when a large elbow pipe weighing an estimated 800-900# fell and struck his left ankle and twisted his left knee. After a conservative trial of chiropractic care and physical therapy, he underwent left ankle arthroscopy with synovectomy and excision of scar on the talofibular ligament on 05/15/03, followed by more physical therapy. Also, an MRI revealed a partial thickness tear of the left ACL for which he is currently considering surgical repair.

REQUESTED SERVICE(S)

The prospective medical necessity of the proposed purchase of an RS4i sequential stimulator, 4-channel combination interferential and muscle stimulator unit.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

The medical records in this case well document that not only did a sufficient injury to the left knee and ankle occur that continues to cause significant pain and disability, but also that utilization thus far of the medical device in question has been efficacious in terms of the patient's case management. Further, a designated doctor examination was performed on 02/28/04, and it was his opinion – which carries presumptive weight – that the patient would not be at MMI for an additional 6 months.

This reviewer disagrees with the carrier's position that "current clinical status not established supporting indefinite use of EMS device." Rather, interferential muscle stimulation has been shown to relieve chronic pain, reduce muscle spasm, prevent disuse muscle atrophy, increase local blood circulation and help increase ranges of motion.¹

Furthermore, the *Journal of Pain* is a reliable reference since it is a peer-reviewed scientific journal that focuses on issues related to pain, including clinical and basic research, patient care, education, and health policy.

¹ Glaser, JA, et al. Electrical Muscle Stimulation as an Adjunct to Exercise Therapy in the Treatment of Non-acute Low Back Pain: A Randomized Trial. *Journal of Pain* 2001; 2: 295-300

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 July 2004.