

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-1411-01
IRO Certificate Number: 5259

June 21, 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 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

59 pages of information were submitted for review. ___ sustained a work related injury on ___. She had a tortuous and protracted course of care with multiple health care providers. Her treatments included off work, medications, IDET, facet injections, epidural steroid injections, physical therapy, chiropractic care, and a multidisciplinary pain program. Apparently, she received a muscle stimulator via ___ on 5/27/99 and an interferential muscle stimulator was prescribed on 2/16/04 for "chronic pain." Of note is that ___ had several underlying psychiatric issues and pre-existing degenerative spine diagnosis.

REQUESTED SERVICE(S)

Purchase of an Interferential Muscle Stimulator.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

No objective evidence is submitted to prove the efficacy of this device for _____. Furthermore, this type of device is useful as an adjunctive therapy in the acute phase of treatment. No accepted peer-review literature or guidelines support the use of a muscle stimulator for chronic pain patients. This view point is supported by the C.M.S., NASS, and the Philadelphia Panel Study. Therefore, the request to purchase this device for indefinite use 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 23rd day of June, 2004.