

MDR Tracking Number: M2-04-1427-01

June 14, 2004
IRO Certificate# 5259

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 ____, 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

There were 59 pages of medical information submitted for review. Apparently ____ was injured on _____. She was treated with physical therapy, medications, a muscle stimulator, and a cervical fusion. Unfortunately, her symptoms persisted, and she was diagnosed with "cervical failed surgery syndrome." Notes recommend a spinal cord stimulator trial and referral to a chronic pain management program but no submitted records document these strategies were implemented.

REQUESTED SERVICE (S)

Purchase of an interferential muscle stimulator

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

No documentation is submitted to support objective evidence of any significant improvement in pain, function, work status or decrease in medications due to the direct result of this device. Of note is a patient usage log where the patient used this device only 18 out of 29 days during one treatment period.

Furthermore, current standard of care and accepted literature and guidelines support the use of this device as an adjunctive therapy in the acute phase of treatment not for chronic or post-surgical pain control. This view is supported by the CMS, NASS, and the Philadelphia Panel Study.

Therefore, the purchase of the interferential muscle stimulator for this patient 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 June 2004.