

## **NOTICE OF INDEPENDENT REVIEW DETERMINATION**

MDR Tracking Number: M2-04-1510-01  
IRO Certificate Number: 5259

July 7, 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

172 pages of records were submitted for review. \_\_\_ was apparently injured on \_\_\_. He was treated with medications, epidural steroid injections, facet injections, physical therapy, rhizotomies, work restrictions, and an interferential muscle stimulator.

### REQUESTED SERVICE(S)

RS4i sequential stimulator 4 channel combination interferential and muscle stimulator unit.

## DECISION

Denied.

## RATIONALE/BASIS FOR DECISION

This type of device is generally used as an adjunctive therapy in the acute phase of treatment. This view is supported by peer-review literature, the CMS, the NASS, and the Philadelphia Panel Study. No body of knowledge or group of experts supports the use of this device for chronic pain.

Furthermore, in this particular case, no significant objective clinical evidence is presented to support the efficacy of this device for this patient. Also, no evidence is submitted to present extraordinary circumstances to justify the continued use of this device outside the usual standard of care. Therefore, the prior decision to deny this device is upheld.

## 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 8th day of July, 2004.