

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0053-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. W, DO

November 22, 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Medical Director

CLINICAL HISTORY

43 pages of records were submitted for review including notes from Dr. W, TWCC forms, GBMCS denial letters, and physician review letters.

In summary, \_\_\_ had a work related neck injury on \_\_\_\_. He was treated conservatively with physical therapy, medication, and a muscle stimulator. He then underwent facet and a series of epidural steroid injections and ultimately underwent a cervical fusion. As of July 2004, he still required multiple medications to manage his continuing pain and associated symptoms.

REQUESTED SERVICE(S)

Purchase of an RS4i Sequential 4 channel combination Interferential & Muscle Stimulator unit.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

\_\_\_ received exhaustive treatment for his neck injury culminating in a cervical fusion. At this point, he is categorized as a chronic pain patient. Unfortunately, these patients are difficult to manage and treat, but no peer review literature or generally accepted guidelines recommend using an IF muscle stimulator for chronic pain and symptoms after a cervical fusion. This device is generally used as an adjunctive therapy in the acute phase of treatment. This view point is supported by CMS and NASS guidelines and the Philadelphia Panel Study. Therefore, this device 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 22<sup>nd</sup> day of November, 2004.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: