

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:	M2-05-0082-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician:	Dr. S, MD
(Treating or Requesting)	

October 14, 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

242 pages of records are submitted for review including multiple physician's notes, physical therapy notes, files from law firms, insurance company documentation, information from R S Medical, and various TWCC forms.

In summary, this patient had a long, protracted course of significant back pain. Originally injured in ____, she failed conservative treatment and multiple ESIs. She underwent a discectomy in April 1998. Apparently, she did well until July, 2001 when symptoms recurred. She again was treated conservatively with medications, physical therapy including aquatic and land based therapy, and multiple ESIs. She underwent a fusion on 1/10/03. On 5/23/03 she had completed a successful, extensive course of physical therapy and was released to a HEP. A prescription to purchase an interferential muscle stimulator was written on 10/2/03. Of note, a muscle stimulator ordered on 3/2/99 was authorized for purchase as well.

REQUESTED SERVICE(S)

To purchase an IF muscle stimulator.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Unfortunately, this patient had a poor outcome from extensive medical and surgical treatments of her back. Some objective evidence is submitted regarding the effectiveness of her muscle stimulator, however, significant objective evidence to justify the purchase of this device is lacking. Furthermore, these types of devices are indicated for use as adjunctive therapy in the acute phase of treatment; not for chronic pain. This view is supported by accepted peer reviewed literature, the Philadelphia Panel Study, and CMS and NASS guidelines. Therefore, the request 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 October, 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: