



# Texas Medical Foundation

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phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

## NOTICE OF INDEPENDENT REVIEW DECISION

December 2, 2004

### Requestor

RS Medical  
Attn: \_\_\_\_\_  
P.O. Box 872650  
Vancouver, WA 98897-2650

### Respondent

Travelers Indemnity of Connecticut c/o FOL  
Attn: \_\_\_\_\_  
505 W. 12<sup>th</sup> Street  
Austin, TX 78701

RE: Injured Worker:  
MDR Tracking #: M2-05-0316-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in orthopedic surgery, by the American Board of Orthopaedic Surgery, licensed by the Texas State Board of Medical Examiners (TSBME) in 1962, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This female patient injured her left knee while performing her job. She has been treated with medication, therapy and the RS4i Sequential Stimulator 4-channel combination Interferential and Muscle Stimulator Unit (RS4i). Her diagnosis is medial femoral condyle chondromalacia focal, left.

### Requested Service(s)

Purchase of a RS4i Sequential Stimulator 4-channel combination Interferential and Muscle Stimulator Unit

### Decision

It is determined that the purchase of a RS4i Sequential Stimulator 4-channel combination Interferential and Muscle Stimulator Unit is not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

This unit is not designed for 24-hour pain control, especially when the problem is caused by weight bearing. The unit will not negate bone-related pain and will not reduce the patient's rehabilitation time or return her to work earlier. The medical records indicate that the patient is not experiencing muscle spasms, or atrophy, and her range of motion is -5 to 120 and quad strength is 5/5. The unit will not change the patient's

functional ability now and is not a permanent cure. All of the settings on this unit are not needed for pain control. The unit will not take away the medical necessity for surgical treatment of the patient's knee.

This decision by the IRO is deemed to be a TWCC decision and order.

### **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 (28 Tex. Admin. Code 142.5 (c)).

**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 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for 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, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

Director of Medical Assessment

GBS:vn

Attachment

cc: \_\_\_\_\_, Injured Worker

Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

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 3rd day of December 2004.

Signature of IRO Employee:

Printed Name of IRO Employee:

### **Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #:** M2-05-0316-01

### **Information Submitted by Requestor:**

- Progress Notes
- Letter of Medical Necessity
- Prescription
- Denials

**Information Submitted by Respondent:** None