

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0467-01
Name of Patient:	
Name of URA/Payer:	Great American Alliance Insurance
Name of Provider:	R S Medical
<small>(ER, Hospital, or Other Facility)</small>	
Name of Physician:	Dr. A, MD
<small>(Treating or Requesting)</small>	

January 19, 2005

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

cc: R S Medical
Dr. A, MD
Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY

Records submitted for review include denial letters from Genex Services, a letter and progress notes from Dr. A, prescriptions from R S Medical, an attorney letter from ____, a request letter from the patient, and denial letters concerning interferential units from various independent review organizations.

The patient sustained an injury on ____ and has had extensive treatments including medications, physical therapy, IDET, and an IF muscle stimulator.

REQUESTED SERVICE(S)

Purchase of an RS4i sequential 4-channel combination interferential and muscle stimulator unit.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

This device is generally used in the acute phase of treatment as an adjunctive therapy. It is not indicated for chronic conditions. This viewpoint is supported by accepted peer-review literature, the Philadelphia Panel Study, and CMS, NASS, ACOEM, and AHCPR 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 19th day of January, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: