

# 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:	M2-05-0502-01
Name of Patient:	
Name of URA/Payer:	Houston ISD
Name of Provider: (ER, Hospital, or Other Facility)	R S Medical
Name of Physician: (Treating or Requesting)	Dr. R, MD

December 21, 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

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

CLINICAL HISTORY

Records for review included a denial letter, RS Medical records, a letter of medical necessity from Dr. R, and an IME from Dr. H. Also, a discharge summary from a pain management program was reviewed.

The original injury was on \_\_\_\_ when this patient sustained a work related injury to her low back and right shoulder. Apparently she underwent extensive evaluation and treatment including surgery to repair her right rotator cuff, but is still having symptoms over one year after her date of injury.

REQUESTED SERVICE(S)

Purchase of an interferential muscle stimulator.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

No objective parameters were submitted to support the use of this device for indefinite use. Furthermore, this type of device is generally used as an adjunctive therapy in the acute phase of treatment. Unfortunately, this patient has chronic pain issues according to the submitted records. No accepted guidelines or peer review literature support the use of this device for chronic pain patients. This view is the consensus in the medical community as standard of care and is supported by NASS and CMS guidelines as well as the Philadelphia Panel Study.

**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 21<sup>st</sup> day of December, 2004.

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

Printed Name of IRO Employee: