

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:	M2-05-0629-01
Name of Patient:	
Name of URA/Payer:	Hartford Underwriters Insurance
Name of Provider: (ER, Hospital, or Other Facility)	R S Medical
Name of Physician: (Treating or Requesting)	Harry Hernandez, DO

January 26, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. 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,

Michael S. Lifshen, MD
Medical Director

cc: R S Medical
Harry Hernandez, DO
____, Texas Workers Compensation Commission

CLINICAL HISTORY

This is a gentleman with a history of low back injury. The date of injury is noted as _____. Treatment included a surgical intervention. Post-operatively there were some complications. It was noted by Dr. Blackburn that there were five separate positive Waddell's signs. Multiple medications were employed with marginal results. An RS4i stimulator was apparently issued. A review by Dr. Sklar noted that there was an increase in the use of medications with similar electrical devices.

REQUESTED SERVICE(S)

Purchase of RS4i stimulator

DECISION

Deny (Endorse pre-authorization)

RATIONALE/BASIS FOR DECISION

The proposed device is not broadly accepted as the prevailing standard of care and is not recommended as medically necessary. Such passive modalities are indicated in the acute phase of care and their use must be time-limited. The Philadelphia Panel Physical Therapy Study found little or no supporting evidence to include such modalities in the treatment of chronic pain greater than 6 weeks. The primary treating physician failed to produce any competent, objective, and independently confirmable medical evidence demonstrating the efficacy of this device. Specifically there has not been any reduction in medication use. The utilization curve is not documented and there is no measurable improvement in this condition. Clearly there is no established positive result from this use of this device. Moreover, there is no clinical assessment made by the primary treating physician that would support the use let alone the purchase of this device. Lastly, this is a passive device and noting the date of injury, this claimant should

be doing only those active modalities that enhance the rehabilitation of this injury. Such passive modalities are indicated in the acute phase of care and their use must be time limited. Moreover, the efficacy of this type of device in the long-term patient has been studied repeatedly. As noted by Herman (Spine 1994 Mar1;19(5):561) this treatment adds no apparent benefit. Lastly as described by Deyo (NEJM 1990 Jun 7(23):127-34) TENS is no more affective than placebo. The literature of blinded peer reviewed studies does not support the efficacy of this device. This device does not improve the situation, there is no identification of a decrease in medication use and the functionality of the claimant was not reported out. There is no discussion in the progress notes of the use of this device only the boilerplate vendor distributed document.

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 27th day of January, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell