

# 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:	M2-05-0651-01
Name of Patient:	
Name of URA/Payer:	Liberty Mutual Fire Insurance
Name of Provider: (ER, Hospital, or Other Facility)	R S Medical
Name of Physician: (Treating or Requesting)	Robert Henderson, MD

January 24, 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,

Michael S. Lifshen, MD  
Medical Director

cc: R S Medical  
Robert Henderson, MD  
Texas Workers Compensation Commission

CLINICAL HISTORY

The following records were submitted for review:

1. Denial letters from Liberty Mutual;
2. Two letters of medical necessity by Dr. Henderson;
3. Information from RS Medical; and
4. A letter from the patient.

In summary, this patient sustained a work related injury on \_\_\_\_\_. He was treated with medications, injections, physical therapy, and a lumbar fusion. He developed symptoms from the hardware, so it was removed July 2004. An interferential muscle stimulator was requested on 7/24/04 for symptoms after the hardware was removed. A prescription to purchase the device for indefinite use.

REQUESTED SERVICE(S)

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

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Insufficient objective evidence to support the medical necessity of this device for this patient was provided. This device is generally used as an adjunctive therapy in the acute phase of treatment. It is not indicated for chronic use. This viewpoint is supported by standard of care and NASS, CMS guidelines as well as the Philadelphia Panel Study. Furthermore, no objective, clinical documentation shows efficacy of this device for this patient. Therefore the request to purchase this device 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 25<sup>th</sup> day of January, 2005.

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

Printed Name of IRO Employee: Cindy Mitchell