

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:	M2-05-0939-01
Name of Patient:	
Name of URA/Payer:	Texas Mutual Insurance Co.
Name of Provider:	R S Medical
<small>(ER, Hospital, or Other Facility)</small>	
Name of Physician:	Ferral Endsley, DO
<small>(Treating or Requesting)</small>	

March 2, 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.

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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: R S Medical
Ferral Endsley, DO
Texas Workers Compensation Commission

RE:

CLINICAL HISTORY

There are 46 pages of documents submitted for review:

- Texas Mutual Insurance company letters;
- R S muscle stimulator prescriptions and additional information;
- Medical records from Dr. Endsley and Dr. Dozier;
- Clinical notes from Samuel Brinkman, Ph.D.
- TWCC form 69 dated 8/5/02; and
- Designated Doctor exam by Dr. Simonsen on 8/5/02.

In summary, this patient had a work related injury on _____. She had extensive evaluation and treatment by multiple doctors which included medications, physical therapy, an ESI, and surgery. She reached MMI on 8/5/02 with a whole-body impairment rating of 10%. An interferential muscle stimulator was prescribed on 8/17/04 for 2 months use and again on 11/12/04 for indefinite use.

REQUESTED SERVICE(S)

Purchase of an interferential muscle stimulator.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

This type of device is generally used as an adjunctive therapy in the acute phase of treatment. No accepted double blinded, peer review studies or guidelines support the use of this device in patients with chronic pain, especially over 2 years after surgery. NASS, CMS, and the Philadelphia Panel support this view.

Furthermore, no objective evidence is submitted such as pharmacy logs or patient usage logs to consider any extraordinary circumstances for this patient. Lastly, Dr. Simonsen's comprehensive evaluation on 8/5/02 concludes this patient has reached MMI on that date with a 10% impairment rating. He stated she is currently taking Xanax for anxiety symptoms related to her injury and possibly other stressors. He writes "She does have some decrease range of motion and she has some evidence that suggests a need for an extension exercise program but beyond that there does not appear to be any treatment other than medication (Xanax) that she requires". Since she had reached MMI on 8/5/02, no justification could be found to purchase a muscle stimulator over 2 years after this designated doctor exam.

Therefore, after delineating several reasons concerning this patient and the purchase of this requested device, no medical necessity is determined for this device and 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 3rd day of March 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell