

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:	M2-05-0950-01
Name of Patient:	
Name of URA/Payer:	American Protection Insurance
Name of Provider: (ER, Hospital, or Other Facility)	R S Medical
Name of Physician: (Treating or Requesting)	A. Mohamed, MD

March 14, 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.

March 14, 2005
Notice of Independent Review Determination
Page 2

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: R S Medical
A. Mohamed, MD
Texas Workers Compensation Commission

RE:

CLINICAL HISTORY

This patient sustained a work related injury on _____. She was seen by multiple physicians and has extensive treatments including medications, physical therapy, TENS unit, interferential muscle stimulator, radiofrequency procedures, injections (ESI and facet), and multiple surgeries. Dr. Oderstony rendered an MMI on 8/12/1999. Dr. Culver submitted a TWCC with a return to work date of 4/27/04 with restrictions. A FCE done 5/9/04 draws the same recommendations. Dr. Mohamed ordered an interferential muscle stimulator on 9/21/04 and re-ordered it 11/16/04 for indefinite use.

Records submitted for review included the following:

- Denial letters from Broadspire;
- Information from R S Medical'
- Medical records from Dr. Mohamed;
- An IME or RME from Dr. Culver; and
- A FCE dated 5/9/04.

REQUESTED SERVICE(S)

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

DECISION

Denied due to lack of objective date to support medical necessity of this device for this patient.

RATIONALE/BASIS FOR DECISION

First, this type of device is generally used as adjunctive therapy in the acute phase of treatment, not for chronic pain situations. This view is supported by accepted peer-review literature, guidelines such as CMS and NASS, and the Philadelphia Panel Study.

Second, no objective evidence is submitted to support the continued use of this device for the patient. In fact, the patient usage log documents the device was used less than 50% of the days from 9/22/04 through 1/13/05. Also, Dr. Riso, Dr. Oderstény and Dr. Culver offer opinions issued prior to the use of this device that this patient has basically reached MMI with restrictions and that further treatment, aside from maintenance medications, was not warranted. Therefore, the prior denial is upheld.

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).

March 14, 2005
Notice of Independent Review Determination
Page 4

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 14th day of March 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell