

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1380-01
Name of Patient:	
Name of URA/Payer:	Liberty Insurance
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Robert Bell, MD

April 28, 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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Notice of Independent Review Determination
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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc:

Robert Bell, MD
Texas Workers Compensation Commission

CLINICAL HISTORY

The following records were submitted for review:

- Information from Liberty Mutual Group including non-authorization letters;
- Letter of medical necessity from Dr. Bell; and
- Records from RS Medical including prescriptions and product literature.

___ had an injury on ____. There is a paucity of clinical information but documentation is submitted that she was treated with physical therapy, medication, and a muscle stimulator. A request to purchase an interferential stimulator and an appeal were not authorized.

REQUESTED SERVICE(S)

Purchase of RS4i interferential muscle stimulator.

DECISION

Uphold prior non-authorization.

RATIONALE/BASIS FOR DECISION

No objective evidence was submitted to support the medical necessity or efficacy of this device for this patient such as a pharmacy log, patient usage log, work status, or improved function. Furthermore, this type of device is generally used as an adjunctive therapy in the acute phase of treatment not for chronic pain patients such as ____. This viewpoint is the standard of care and supported by NASS, CMS,

ACOEM guidelines as well as the Philadelphia Panel Study. Therefore, the purchase of an interferential muscle stimulator for this patient is not authorized.

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 28th day of April, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell