

# 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:	M2-05-1405-01
Name of Patient:	
Name of URA/Payer:	Bankers Standard Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	R S Medical
Name of Physician: (Treating or Requesting)	Kyle Jones, MD

May 12, 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  
Kyle Jones, MD  
Texas Workers Compensation Commission

#### CLINICAL HISTORY

Records were submitted from various sources including:

- Intracorp denial letters;
- RS Medical records including patient reports;
- Progress notes and letters of medical necessity from Dr. Jones;
- MRI and CT reports;
- Retrospective Peer Review from 5/4/04 from Drs. Blanchette and Mathews;
- An IME on 4/1/96 by Dr. Perry; and
- ER records;

In summary, this patient sustained a back injury on \_\_\_\_\_. He was extensively evaluated and treated by several doctors. Treatments included medications, facet injections, trigger point injections, physical therapy, pain management program, and a muscle stimulator. Apparently he had an acute flare up treated in the ER in August 2004.

#### REQUESTED SERVICE(S)

Purchase of an RS4i sequential a4-channel combo interferential and muscle stimulator.

#### DECISION

Denied.

#### RATIONALE/BASIS FOR DECISION

Unfortunately this patient has chronic back pain as he is still having symptoms from an injury on \_\_\_\_\_. A muscle stimulator would not be medically reasonable or necessary at this point in his care. Even considering an acute flare up in August 2004, the request to purchase the device was dated 10/28/04 which is outside the acute phase of treatment for this flare up. This viewpoint is consistent with NASS and CMS guidelines and the Philadelphia Panel Study. Furthermore, no

objective evidence is submitted to show the efficacy of this device for this patient. Therefore, prior denial is being 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).

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 16<sup>th</sup> day of May 2005.

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

Printed Name of IRO Employee: Cindy Mitchell