

# 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:	M2-05-1735-01
Name of Patient:	
Name of URA/Payer:	Specialty Risk Services
Name of Provider: (ER, Hospital, or Other Facility)	R S Medical
Name of Physician: (Treating or Requesting)	Bill Weldon, DO

June 21, 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  
Bill Weldon, DO  
Texas Workers Compensation Commission

#### CLINICAL HISTORY

Records were submitted for review from the following:

- Progress notes and letters of medical necessity from Dr. Weldon;
- Product information and article from R S Medical;
- Hartford Insurance; and
- SRS.

Mr. \_\_\_ sustained an injury on \_\_\_\_. Apparently he was treated with medications, physical therapy, facet injections, and a muscle stimulator. A request for chronic pain management was denied and it is unclear if this was approved or attended to by the patient later.

#### REQUESTED SERVICE(S)

Purchase of an RS4i muscle stimulator.

#### DECISION

Denied.

#### RATIONALE/BASIS FOR DECISION

No objective evidence was submitted to support the efficacy or medical necessity of this device. Furthermore, no accepted guidelines or peer-reviewed medical literature support the use of this device for chronic pain symptoms. This view point is supported by ACOEM guidelines, CMS guidelines, and the Philadelphia Panel Study. The article to support the use of this device is not credible because of the large drop-out rate and low number of patients in the study. Thus, 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 21<sup>st</sup> day of June 2005.

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

Printed Name of IRO Employee: Cindy Mitchell