

# 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:	M2-05-2141-01
Name of Patient:	
Name of URA/Payer:	Sentry Insurance
Name of Provider:	R S Medical
<small>(ER, Hospital, or Other Facility)</small>	
Name of Physician:	Aaron K. Calodney, MD
<small>(Treating or Requesting)</small>	

August 16, 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  
Aaron K. Calodney, MD  
Texas Workers Compensation Commission

#### CLINICAL HISTORY

Records submitted for review consisted of the following:

- Progress notes from Dr. Calodney and Nicole Butcher, PA;
- Denial letters from IntraCorp
- Letter from Mr. \_\_\_\_;
- Records from R S Medical including the prescriptions for the muscle stimulator and a patient usage log; and
- Letter from W. Jon Grove, attorney.

It appears Mr. \_\_\_\_ sustained an injury to his cervical spine on \_\_\_\_\_. (Apparently he also had a significant back injury in \_\_\_\_\_ but this diagnosis is not part of the current request or review for the muscle stimulator.) Although records before December 2004 were not submitted, the reviewed information reflect Mr. \_\_\_\_ was treated with medications, trigger point injections, C5-6 fusion, and a muscle stimulator. The prescriptions for the muscle stimulator note cervical epidural steroid injections were done previously. A request to purchase an interferential muscle stimulator was denied and an appeal upheld the denial.

#### REQUESTED SERVICE(S)

Purchase of an interferential muscle stimulator for chronic cervical pain/cervicalgia.

#### DECISION

Uphold previous denial.

#### RATIONALE/BASIS FOR DECISION

At this stage of his diagnosis and treatment, this patient has chronic neck pain. No objective evidence was submitted to document the efficacy of this unit for this patient. Even with the muscle stimulator, he continues to take multiple medications and, per his letter, is totally

disabled. His patient usage log shows he used the unit only 21 out of 29 days. With severe and intense muscle spasms and pain twice a day as noted by Dr. Calodney and if this unit was efficacious, it would seem his compliance would be greater.

Furthermore, no peer reviewed literature or accepted guidelines support the use of this device for chronic, post fusion cervical pain. This view point is supported by ACOEM, CMS, and NASS guidelines as well as the Philadelphia Panel Study. Therefore, this unit does not appear medically necessary for this patient for this diagnosis at this time, so the reason 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 17<sup>th</sup> day of August 2005.

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

Printed Name of IRO Employee: Cindy Mitchell