

Parker Healthcare Management Organization, Inc.

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972.906.0603 972.906.0615 (fax)

Certificate # 5301

May 16, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: _____

RE: Independent review for M2-05-1464-01

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 4.19.05.
- Fax request for provider records made on 4.21.05.
- The case was assigned to a reviewer on 5.2.05.
- The reviewer rendered a determination on 5.12.05.
- The Notice of Determination was sent on 5.16.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of proposed purchase of a RS4I sequential, 4 channel combination interferential and muscle stimulator

Summary of Clinical History

Ms. ___ is a teacher at _____. She sustained an on the job injury ____, when a student threw a dictionary, hitting her in the head. She has undergone treatment for headaches and neck pain.

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **uphold the denial**.

Clinical Rationale

The denial is upheld because of insufficient clinical evidence provided with the records to determine exactly what benefit the RS4I sequential, 4 channel combination interferential and muscle stimulator was to the patient, during a trial period or any other usage to support a purchase. There is no supplied

documentation which demonstrates that the patient has significantly improved and as of 3/1/05, she had continued to use significant amounts of pain medications. The device has not been scientifically indicated for the control of pain. There is no medical literature which demonstrates the effectiveness of this device in relieving pain. Therefore, in this case, the medical necessity of this unit to this patient was not established.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 10 years of patient care and orthopedic surgery.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is a diplomat of the American Board of Orthopedic Surgery, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

In accordance with TWCC Rule 102.4 (h), a copy of this decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 16th day of May 2005.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas
Administrator

CC:

RS Medical
Attn: Joe Basham
Fax: 800.929.1930

Attn: Ron McClendon
Fax: 210.681.8617