

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-0011-01
Name of Patient:	
Name of URA/Payer:	Liberty Mutual
Name of Provider: (ER, Hospital, or Other Facility)	R S Medical
Name of Physician: (Treating or Requesting)	Robert Sickler, MD

September 29, 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 the Division of Workers' Compensation 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
Robert Sickler, MD
Division of Workers' Compensation

CLINICAL HISTORY

Records submitted for review included:

- Liberty Mutual records;
- Prescriptions for the RS muscle stimulator;
- Progress notes from Dr. Sickler and Dr. Chang;
- Two Peer Review Analysis Reports;
- TWCC forms; and
- Testimonial letter from ____ ____.

Mr. ____ sustained injuries in a work related Moving Vehicle Accident (MVA) on _____. He was treated conservatively with medications and physical therapy. Unfortunately, his symptoms continued and he underwent two cervical surgeries. His pain continued and he was treated with medications, a muscle stimulator, and trigger point injections. A spinal cord stimulator, ESIs, and facet injections were discussed but not pursued at this time.

REQUESTED SERVICE(S)

Purchase of an RS4i muscle stimulator.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Mr. ____ continues to have pain symptoms after extensive treatment for his neck. He is now a chronic pain patient and is diagnosed with cervical post laminectomy syndrome. A muscle stimulator is not indicated or medically necessary for chronic pain patients or patients' status post cervical fusion surgery. This viewpoint is supported by CMS and ACOEM guidelines, the Philadelphia Panel Study, and numerous articles and books including *Essentials of Pain Medicine and Regional Anesthesia* (Benzon, 2005) and *Pain Procedures in Clinical Practice* (Lennard 2002).

Furthermore, no objective evidence is submitted to show the long term efficacy of this device for this patient. In fact, Dr. Sickler's note on 7/11/05 documents an increase in pain while using the device and on medications. Also, the patient usage log shows a pattern of non-compliance with this stimulator from April 2005 through July 2005. For these reasons, prior non-authorization is upheld.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings
Division of Workers' Compensation
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 30th day of September 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell