

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	_____
MDR Tracking Number:	M2-06-0174-01
Name of Patient:	_____
Name of URA/Payer:	Ace/ESIS
Name of Provider: (ER, Hospital, or Other Facility)	R S Medical
Name of Physician: (Treating or Requesting)	Robert Henderson, MD

November 1, 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.

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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
R S Medical
Robert Henderson, MD
Division of Workers' Compensation

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RE: ____

CLINICAL HISTORY

Records submitted for review included:

- Intracorp denial letters;
- Clinical notes and a letter of medical necessity from Dr. Henderson;
- Patient usage logs and trial assessment; and
- Patient testimonial letters.

Mr. ____ sustained a work related back injury on _____. He had two back surgeries prior to this injury. He was treated with physical therapy and medications for his current injury. He continued to have pain at least five months after his most recent surgery on 5/17/05. A request to purchase a muscle stimulator and an appeal were denied.

REQUESTED SERVICE(S)

Purchase of an interferential muscle stimulator.

DECISION

Uphold prior non-certification.

RATIONALE/BASIS FOR DECISION

No objective evidence was submitted to justify the purchase of this device for this patient. Furthermore, no peer review literature or generally accepted guidelines support the use of this device for chronic back pain or post surgical patients. This view is supported by CMS, ACOEM, and National Clearinghouse guidelines and the Philadelphia Panel Study. Therefore, the purchase of the interferential muscle stimulator is not authorized for this patient.

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RE: _____

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that all of the above statements are, to the best of my knowledge and belief, true and correct to the extent they are applicable to this case and my relationships. I understand that a false certification is subject to penalty under applicable law.

1. I had no previous knowledge of this case prior to it being assigned to me for review.
2. I have no business or personal relationship with any of the physicians or other parties who have provided care or advice regarding this case.
3. I do not have admitting privileges or an ownership interest (of 5% or more or \$100,000 or above, whichever is less) in the health care facilities where care was provided or is recommended to be provided. I am not a member of the board or advisor to the board of directors or any of the officers at any of the facilities.
4. I do not have a contract with or an ownership interest (of 5% or more or \$100,000 or above, whichever is less) in the utilization review agent, the insurer, the health maintenance organization, other managed care entity, payer or any other party to this case. I am not a member of the board or advisor to the board of directors or an officer for any of the above referenced entities.
5. I have performed this review without bias for or against the utilization review agent, the insurer, health maintenance organization, other managed care entity, payer or any other party to this case.

I hereby further attest that I remain active in my health care practice and that I am currently licensed, registered, or certified, as applicable, and in good standing.

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 1st day of November 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell