

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

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Austin, Texas 78735

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-0671-01
Name of Patient:	
Name of URA/Payer:	American Home Assurance/F.O.L.
Name of Provider: (ER, Hospital, or Other Facility)	R S Medical
Name of Physician: (Treating or Requesting)	Christopher Meyer

March 29, 2006

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
Christopher Meyer, MD
Division of Workers' Compensation

CLINICAL HISTORY

The following records were submitted for review:

- Clinical notes from Dr. Meyer;
- Dr. Cochran's denial letter;
- An appeal letter denied by Dr. Simpson;
- Department of Health and Human Services letters;
- R S patient usage logs;
- Multiple guidelines; and
- Multiple prior adverse determination letters from various IRO's.

This gentleman sustained a work related injury. He had extensive conservative treatments but eventually required anterior cervical fusion. He continued to experience symptoms after his surgery.

REQUESTED SERVICE(S)

Purchase of an interferential muscle stimulator.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

This device is generally used as adjunctive treatment in the acute phase of treatment. There is no peer review literature, clinically accepted guidelines, or objective evidence presented that support the medical necessity of this device for a patient with chronic pain after an anterior fusion of C3-4. This viewpoint is supported by ACOEM and CMS guidelines, the Philadelphia Panel Study, and standard of care. Therefore, the purchase of this device for this patient is not justified and the prior denial is upheld.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

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 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 March 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell