THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-02-3527.M5

MDR Tracking Number: M5-02-1952-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Medical Review Division has reviewed the IRO decision. The IRO did not clearly determine the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the Commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The cervical pillow and moist heating pad were found to be medically necessary. The Pulsed Galvanic stimulator was not medically necessary.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
8/8/01	E0745 E1399-D6	475.00 85.00	0.00 0.00	U U	DOP DOP	IRO decision	The IRO determined this DME was not medically necessary and therefore not reimbursable. Since DME was not medically necessary, the supplies would therefore not be reimbursable as well.
8/8/01	E1399-NU	239.00	0.00	U	DOP	§133.1(a)(8)	The IRO determined this DME was medically necessary. The carrier did not object to fair and reasonable reimbursement, therefore, reimbursement is recommended as billed, **$239.00**.
8/8/01	E0215-NU	80.75	0.00	U	DOP	§133.1(a)(8)	Same as above reimbursement is recommended as billed,

							$80.75.
TOTAL		$879.75					The requestor is entitled to reimbursement of **$319.75.**

On this basis, the total amount recommended for reimbursement ($319.75) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay $319.75 plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 8/8/01 in this dispute.

This Order is hereby issued this 28th day of, May 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

April 1, 2002
Texas Workers' Compensation Commission
David R. Martinez, Chief
Medical Dispute Resolution
4000 South IH-35, MS 40
Austin, TX 78704-7491

Attention: Carol Lawrence

Re: Medical Dispute Resolution
MDR #: M5-02-1952-01
IRO Certificate No.: I RO 5055

Dear Ms. Lawrence:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a Physician Board Certified in Neurology and Pain Management.

THE PHYSICIAN REVIEWER OF THIS CASE PARTIALLY AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE. THE CERVICAL

PILLOW AND MOIST HEATING PAD WERE MEDICALLY NECESSARY. THE PULSED GALVANIC STIMULATOR WAS NOT MEDICALLY NECESSARY.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

Secretary & General Counsel

Enclosure (1)

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning Case File #M5-02-1952-01, in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution request.
2. Peer review from ___, dated 9/24/01.
3. Operative report dated 3/19/01, by ___.
4. EMG report dated 6/11/01, by ___.
5. Return patient visit dated 7/30/01.
6. Medical equipment description supplied by ___, regarding pressure relief pillow and pulsed galvanic stimulator.

B. SUMMARY OF EVENTS:

It appears that the claimant sustained a work-related injury on ___ and subsequently underwent an anterior cervical fusion of C-4 through C-6 in January of 2000. She reportedly returned to work in February of 2000, but apparently continues to have difficulties with pain as well as intermittent paresthesias in the bilateral upper extremities. There is some documentation on the EMG report that muscle examination does reveal some trigger points in the posterior cervical paravertebral region.

Because of continued symptoms, a cervical pillow, moist heating pad, and galvanic stimulator were prescribed.

C. OPINION:

I believe that continued attempts at the patient's lingering symptoms are appropriate and necessary. Specifically, I feel that the cervical pillow and cervical moist heating pad may be reasonable in attempting to control some of the persistent pain that is presumably due to persistent myofascial pain in trigger points, etc.

On the other hand, I do not believe that the galvanic stimulator would be of much utility at this stage. It is my understanding that this device is meant more for acute situations, which certainly would not apply here.

I PARTIALLY AGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

I believe that attempts at controlling the patient's persistent symptoms, presumably from lingering myofascial pain, would be reasonable and medically necessary and that the cervical pillow and heating pad may play a role in this endeavor.

However, I am in agreement that the pulsed galvanic stimulator will be of low utility. The documentation provided by ___ themselves states that this device is used more for "acute stage of rehabilitation," and it is certainly my understanding that this type of device is more beneficial in reducing acute swelling and inflammation from acute injuries.

IN SUMMARY, I am in agreement with the peer reviewer that the galvanic stimulator is not medically necessary, but disagree with the decision regarding the cervical pillow and heating pad, as I feel that these would be reasonable and medically necessary to treat ongoing myofascial pain symptoms.

D. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

_____

Date: 29 March 2002