

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

SOAH DOCKET NO. 453-03-0924.M5

MDR Tracking Number: M5-02-2170-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the constant application of cryotherapy rendered was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that application of cryotherapy fees were the only fees involved in the medical dispute to be resolved. As the treatment, constant application of cryotherapy, was not found to be medically necessary, reimbursement for date of service 5/8/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 5th day of September 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

September 3, 2002

REVISED CORRESPONDENCE

Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Attention: Rosalinda Lopez

Re: Medical Dispute Resolution
MDR #: M5-02-2170-01
IRO Certificate No.: 5055

Dear Ms. Lopez:

Following is a revision to the letter to the Commission dated 06/07/02 regarding the above-named case review. Note revision to wording of page 2, paragraph 2 (“REQUESTOR” to RESPONDENT”), as well as the additional information added regarding the reviewer’s opinion.

The following independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a Doctor of Chiropractic Medicine.

The reviewer AGREES with the determination of the respondent in this case. The reviewer is of the opinion that aggressive, constant application of cryotherapy is not medically necessitated in this case.

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.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning Case File #M5-02-2170-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution Request/Response.
2. EOB denying payment for cryotherapy unit.
3. Medical review on May 7, 2002, by ___.
4. Peer review report dated 8/02/01.
5. Pre-authorization questions answered sheet.
6. ___, chiropractor, SOAP notes, dated 3/21/01 through 5/08/02.
7. Request for consideration by ___, dated 6/22/01.
8. Letter of medical necessity by ___.
9. An electric ice cooler script by ___, dated 4/30/01.

B. SUMMARY OF EVENTS:

The patient injured herself on ___. The initial diagnosis was cumulative stress disorder with the hands, arms, and neck identified from the 9/11/97 work-related injury. She has been treated by 26 different doctors. Subsequent diagnosis is carpal tunnel syndrome bilaterally, cervical IVD syndrome, and cervicobrachial

syndrome. Microdiskectomy (anterior cervical) for posterior osteophytes at C5-C6 and C6-C7 was recommended by a neurosurgeon. Neurodiagnostic EMG/NCV was performed on 11/20/00, with results unclear and not provided to me for review. Cervical spine surgery was approved by the insurance company but expired on 1/19/02.

The patient has declined from having surgery as of 1/19/02. She has been treated by ___ who has recommended a cold therapy unit (\$745.20) for home use, in May of 2001. He has been utilizing light-force manipulation to the cervical spine, and hot packs and sensory level electric stimulation. Treatment notes by ___ are from 3/21/01 to 5/08/02.

The patient documented symptoms each visit at 6 to 8 in intensity of pain to the cervical spine. No radiculopathy with sensory or motor abnormalities is noted in ___ SOAP notes. It is noted that the patient is totally disabled.

C. OPINION:

I AGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

No documented recommendations with rationale specific to this patient were submitted by the treating doctor or other doctors involved in the care of this patient to support the use of this cryo unit.

The letter of medical necessity was signed by ___ and identified the cryo unit's post-surgical applications. I am not aware and it is not documented that the patient had cervical surgery.

No specific findings or diagnosis supported by diagnostic testing was submitted to support the application of the cryo unit.

No pre- and post-functional assessment with rationale for treatment plan information was submitted or was not contained in the medical information reviewed. Of the many other doctors who saw this patient, no one supported or recommended this application at this time.

Most applications of the cryo unit distributed by DME companies are for more aggressive constant application of cryotherapy where the patient is totally or partially non-ambulatory; for example, post-surgical, acute traumatic, and recurrent exacerbation with inflammation conditions. These are more critical and practical situations for its application.

This patient is capable of applying, participating in, and following through more appropriate and effective therapy applications for her condition; for example, static, isometric, concentric, and reciprocal inhibition stretching, as well as

isometric, concentric, and eccentric strengthening, as well as proprioception and stabilization rehabilitation routines for home use. Ice packs would be appropriate in her case because they are effective for her application. She is ambulatory and could manage using ice packs just fine.

The sources of screening criteria includes over 17 years of clinical practice experience, spinal treatment guidelines, and Delphi rehabilitation protocols.

In summary, my reasons for agreeing with the insurance company are:

1. No documented recommendations with rationale specific to this patient supported and recommended by the other 25 doctors who have seen this patient.
2. Specific diagnosis and condition not identified with rationale for use of cryo unit.
3. No functional data pre and post supporting this use.
4. Aggressive-constant application of cryotherapy is not medically necessitated with this condition.
5. The patient is capable in applying and utilizing ice packs effectively.

D. ADDITIONAL COMMENTS:

None.

E. 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: 7 June 2002