

MDR Tracking Number: M5-02-2364-01

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 DME (including: two form fitting conducting garments, neuromuscular stimulator, portable whirlpool and miscellaneous supplies) were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that DME fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for date of service 3/29/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 3rd day of January 2003.

Carol R. Lawrence  
Medical Dispute Resolution Officer  
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

November 20, 2002

Rosalinda Lopez  
Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
4000 South IH-35, MS 48  
Austin, TX 78704-7491

RE: MDR Tracking #: M5-02-2364-01  
IRO Certificate #: 4326

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care.

\_\_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to \_\_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

#### Clinical History

This 39 year old female sustained a work related injury on \_\_\_\_\_. The origin and exact nature of the injury were not identified in the information submitted for review. The information submitted by the requestor, which included chiropractic progress notes from 03/21/01 through 10/19/01, indicated that the patient has been treated for pain in her neck, upper extremities and upper back. The treating chiropractor's letter of medical necessity, dated 10/23/02, indicated that the patient had a positive MRI, CT myelogram, ongoing pain and neurological symptoms, and subsequently required the 2 form fitting conduction garments, neuromuscular stimulator, portable whirlpool and durable medical equipment (DME) supplies for the 03/29/01 date of service.

#### Requested Service(s)

Two form fitting conduction garments, neuromuscular stimulator, portable whirlpool and DME supplies for the 03/29/01 date of service.

#### Decision

It has been determined that the two form fitting conduction garments, neuromuscular stimulator, portable whirlpool and DME supplies for 03/29/01 date of service were not medically necessary.

#### Rationale/Basis for Decision

The documentation submitted for review did not contain clinical information related to the origin and type of injury, or a complete diagnostic and treatment history. The record reflects a chronic condition. The assessment of a chronic pain patient requires an interdisciplinary care plan and the records provided for review did not include a plan of care that warranted the DME and supplies. Guidelines published in 1999 by the American Medical Directors Association outlined protocols for the management of chronic pain. Therefore, based on the documentation submitted for review, the two form fitting conduction garments, neuromuscular stimulator, portable whirlpool and DME supplies for 03/29/01 date of service were not medically necessary.

Sincerely,