

MDR Tracking Number: M5-02-2480-01

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 neuromuscular stimulator and related supplies were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the fees for neuromuscular stimulator and related supplies 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 6-1-01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 24<sup>th</sup> day of September 2002.

Dee Z. Torres, Medical Dispute Resolution Officer  
Medical Review Division

DZT/dzt

August 30, 2002

Re: Medical Dispute Resolution  
MDR #: M5-02-2480-01  
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records 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. Your case was reviewed by a physician Board Certified in Anesthesiology.

**The physician reviewer AGREES with the determination made by the insurance carrier in this case. The reviewer is of the opinion that a neuromuscular stimulator, water circulating unit, cooler wrap and cooler pad are not medically necessary in this case.**

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician 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. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by \_\_\_ is deemed to be a Commission decision and order.

#### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **ten (10)** days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **twenty (20)** days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5)** days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 78704-0012

**A copy of this decision should be attached to the request.** The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

**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 10<sup>th</sup> day of July 2002.**

Sincerely,

### **MEDICAL CASE REVIEW**

This is for \_\_\_\_\_. I have reviewed the medical information forwarded to me concerning TWCC Case File #M5-02-2480-01 in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. TWCC IRO Assignment, dated 7/01/02, one page.
2. TWCC-60, Medical Dispute Resolution Request/Response, dated 7/01/02, 2 pages.
3. TWCC-60, Table of Disputed Services form, 5/01/01 through 6/01/01, two pages.
4. TWCC-62, Explanation of Benefits, dated 8/21/01, for office visits from 6/01/01 through 6/30/01, from the carrier, \_\_\_\_\_.
5. Letter of medical necessity from \_\_\_\_\_, in reference to water circulating unit, cooler wrap, and cooler pad, dated 7/09/02, one page.
6. Generic letter of medical necessity for pulsed galvanic stimulator from \_\_\_\_\_, one page.
7. Generic letter of medical necessity for PGS training and fitting, one page.
8. Generic letter of medical necessity for electromesh/back with ThermoStim conductive garments, one page.
9. Product information sheets:
  - a) polar wraps, 2 pages.
  - b) Smart-Wave galvanic stimulator, 4 pages.
  - c) ThermoStim electro-garment, 2 pages.

B. BRIEF CLINICAL HISTORY:

The patient was injured at work while employed by \_\_\_\_\_ on \_\_\_\_\_. His treating physician is \_\_\_\_\_, who assigned him the following diagnoses: 723.1, cervicalgia; 719.41, pain in the joint, shoulder; 724.2, lumbago; 719.42, pain in joint, upper extremity.

C. DISPUTED SERVICES:

The requestor for the disputed services is \_\_\_\_, with the respondent being listed as \_\_\_\_\_. It appears from the documentation reviewed that the dispute concerns non-payment for durable medical equipment including a neuromuscular stimulator, water cooling unit, cooler wrap, and cooler pads.

D. DECISION:

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

E. RATIONALE OR BASIS FOR DECISION:

\_\_\_\_\_ did not provide medical information supporting their position for the services rendered. The documentation submitted does not support the medical necessity of the treatment/service/DME provided.

F. 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: 22 August 2002