

MDR Tracking Number: M5-02-2497-01

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 circulating cold-water unit, cold therapy, wrap pad, and adaptor was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that circulating cold-water unit, cold therapy, wraps pad, and adaptor 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 3-14-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 7th day of October 2002.

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

DZT/dzt

September 30, 2002

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

REVISED CORRESPONDENCE AND MEDICAL REPORT

Attention: Rosalinda Lopez

Re: Medical Dispute Resolution
MDR #: M5-02-2497-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

This is to replace our correspondence and medical case review of 09/24/02 regarding the above-named medical dispute.

This is to correct the reviewer's reference in the medical case review to the incorrect date of injury. The report stated ____, when the correct date of injury is ____.

The reviewer AGREES with the determination of the insurance carrier. The reviewer is of the opinion that the circulating cold-water unit, cold therapy, wrap pad and adapter were 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.

Sincerely,

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning MDR #M5-02-2497-01, in the area of Anesthesiology and Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of water circulating unit, unit wrap, unit pad, and auto-adapter.
2. Correspondence.
3. History and physical and office notes.
4. Operative report.

B. BRIEF CLINICAL HISTORY:

The patient is a 39- to 40-year-old female who sustained an apparent work-related lumbar spinal injury on _____. On 3/14/02, the patient underwent an L2-3 partial lumbar laminectomy for spinal stenosis. A circulating cold-water unit was apparently prescribed on 3/14/02. At one month postoperative follow-up, the patient was reported to have made "very good progress."

C. DISPUTED SERVICES:

Water circulating unit, unit wrap, unit pad, and auto-adapter.

D. DECISION:

I AGREE WITH THE ___ DETERMINATION THAT THE CIRCULATING COLD-WATER UNIT, COLD THERAPY WRAP PAD, AND ADAPTER WERE NOT MEDICALLY NECESSARY.

E. RATIONALE OR BASIS FOR DECISION:

I assume, but the data submitted does not confirm, that the cold therapy was prescribed for the acute postoperative period only. Cold therapy is an accepted modality for total knee arthroplasty and anterior cruciate ligament reconstruction. Additionally, there is wide acceptance for other arthroscopic knee repairs. In these settings, pain control, reduced inflammation, and potentially reduced blood loss can be achieved. There are no controlled outcome studies with regard to lumbar laminectomy. There is no evidence presented that this patient's pain could not be controlled with traditional analgesic regimens. No evidence of narcotic tolerance or intolerance is presented.

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: 23 September 2002