

MDR Tracking Number: M5-02-2736-01

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 Hyperbaric Oxygen Therapy rendered was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that Hyperbaric Oxygen Therapy fees were the only fees involved in the medical dispute to be resolved. As the treatment, Hyperbaric Oxygen Therapy was not found to be medically necessary, reimbursement for dates of service from 7/2/01 through 12/31/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 14th day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

October 14, 2002

Re: IRO Case # M5-02-2736-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a

claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Emergency medicine with a subspecialty in Undersea/Hyperbaric Medicine. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this, based on the medical records provided, is as follows:

History

The patient was in a motor vehicle accident in ____. Reportedly there was an airbag inflation problem and the patient received chemical burns to her hands and inhaled air bag chemicals. Since the motor vehicle accident the patient has had multiple symptoms, including headaches, shortness of breath, nausea, weakness, dizziness, hypersensitivity, inability to concentrate.

Requested Service(s)

Hyperbaric Oxygen Therapy 7/2/01 – 12/3/01

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

The patient does not have a medical condition for which long-term use of hyperbaric oxygen is indicated. There have been no randomized double blind studies or substantial clinical studies to support the use of hyperbaric oxygen therapy for this patient's condition. There is no support from the Undersea Hyperbaric Medical Society 1999 Committee Report for use of hyperbaric oxygen therapy for this patient's condition.

This medical necessity decision by an Independent Review Organization 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 the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) 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 Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

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

Sincerely,