

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

SOAH DOCKET NO. 453-04-2739.M5

MDR Tracking Number: M5-04-0560-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General 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 dispute was received on October 23, 2003.

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 unlisted procedure, nervous system was 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 fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above was not found to be medically necessary, reimbursement for dates of service from 01-20-03 to 02-21-03 are denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 30th day of December 2003.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PNR/pnr

December 18, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-04-0560-01
IRO #: 5251

_____ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Psychiatry. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This patient had a back injury when 40 to 50 pound box of chicken fell on her back. She underwent extensive treatments, both conservative and tertiary. She has had lumbar surgery, numerous injections, psychotherapy, biofeedback, anti-depressant medications and injections. This patient has also been through a chronic pain management program. She recently has been receiving “Dynatron STS” treatment for chronic pain and this has helped to a degree.

The documentation does not show any peer reviewed literature for the effectiveness of this procedure. The only information is the marketing sheet and the clinician’s log of treatment. The log has pre- and post-treatment pain levels using a visual analog scale of 1 to 10. Of 19 treatments, there is a slight decrease in pain for only one session. The remaining sessions have either no improvement, worsening, or no recording of post- or pre-treatment levels of pain. The documentation does not show that the Dynatron STS is consistently helpful for this patient.

DISPUTED SERVICES

Under dispute is the medical necessity of unlisted procedure, nervous system from 1/20/03 through 2/21/03.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The medical necessity for the treatments could not be justified, as they were neither objectively or subjectively helpful in consistently lowering the patient's perceived pain. Medical necessity could also not be justified due to a lack of objective peer-reviewed literature to support the efficacy of this treatment.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,