



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: SSI DME Solutions, LP 605 Overland Trail Southlake, Texas 76092	MDR Tracking No.: M5-06-1374-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Rep Box # 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute
POSITION SUMMARY: None submitted by Requestor

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: "Texas Mutual requests that the request for dispute resolution filed by SSI DME SOLUTIONS INC. be conducted under the provisions of the APA set out above".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-20-05	Pump for water circulating pad and pad for water circulating heat unit	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

06-26-06

Authorized Signature

Typed Name

Date of Findings and Decision

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity
IRO Decision Notification Letter**

Date:	06/07/2006
Injured Employee:	
MDR #:	M5-06-1374-01
DWC #:	
MCMC Certification #:	TDI IRO-5294

REQUESTED SERVICES:

Please review the item(s) in dispute: Were the pump for water circulating pad E0236 and pad for water circulating heat unit E0249 on 09/20/2005 medically necessary?

DECISION: Upheld

IRO MCMCIIc (MCMC) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO) to render a recommendation regarding the medical necessity of the above disputed service.

Please be advised that a MCMC Physician Advisor has determined that your request for an M5 Retrospective Medical Dispute Resolution on 06/07/2006, concerning the medical necessity of the above referenced requested service, hereby finds the following:

The pump for the water circulating pad and the pad for the circulating heat unit are not medically necessary.

CLINICAL HISTORY:

This male injured individual was to undergo lumbar surgery. On 09/20/2005 Dr. Henderson signed a prescription for a cold therapy unit.

REFERENCE:

The Spine: Orthopedic Knowledge Update by AAOS, 2002.

RATIONALE:

The letter of medical necessity dated 12/28/2005 documents that Dr. Henderson uses the cold therapy unit as part of his post-operative protocol after lumbar surgery to "deliver the modality of cold treatment about the operative site".

Dr. Henderson goes on to state that he "strongly believes[s] in the significant benefits that this type of therapy provides." The device allegedly allows the application of cold close to the operative site without the "concerns of leakage from ice bags and contamination of the sterile wound". To date there is no scientific data to show that the use of ice bags increases the risk of infection of the operative site.

The few available reports are essentially collections of case reports. There was no evidence to show that the Unit decreased hospital stay, enhanced recovery post-operatively, and resulted in better outcomes. There were major flaws in these reports. No allowance was made for the placebo effect, and the numerous biases were not eliminated. Furthermore, the selection and evaluation criteria, measurement of pain, influence of pre-morbid medical condition, motivation of the patient, pre-operative pain threshold are not described. The reports are replete with confounding factors that decrease, if not eliminate the validity, reliability or credibility of the conclusions that are based on very small numbers. Thus, extrapolation of these conclusions, on a more general scale, leads to misleading assumptions about the need for or effectiveness of the electronic thermal device in altering the outcomes of surgery.

At present, the primary force driving the need for the cold therapy device appear to be the marketing efforts of the manufacturer. The various benefits said to result with the use of the device remain unproven. There is no objective scientific study to confirm these claims; rather the proof consists of a pastiche of isolated scientific facts each of which is independently accurate. However, combining these isolated scientific facts does not constitute support for the alleged effectiveness of the Unit. There is to date no scientific data from well designed studies to show that the use of the cold therapy unit is either necessary or effective in improving the outcomes of lumbar surgery.

RECORDS REVIEWED:

- Notification of IRO Assignment dated 04/27/06
- MR-117 dated 04/27/06
- DWC-60
- MCMC: IRO Medical Dispute Resolution Retrospective Medical Necessity dated 05/09/06
- MCMC: IRO Acknowledgment and Invoice Notification Letter dated 04/27/06
- MCMC: Invoice dated 04/28/06
- SSI DME Solutions: Check dated 05/03/06 totaling \$460.00
- Texas Mutual: Letter dated 04/11/06
- Texas Mutual: Explanation of Benefits with date of audit 03/15/06
- Dallas Spine Care: Letter dated 12/28/05 from Robert Henderson, M.D.
- DME Solutions: DME/Orthotic Prescription dated 09/20/05

The reviewing provider is a Licensed/Boarded Orthopedic Surgeon and certifies that no known conflict of interest exists between the reviewing Orthopedic Surgeon and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision prior to referral to the IRO. The reviewing physician is on DWC's Approved Doctor List.

This decision by MCMC is deemed to be a Division decision and order (133.308(p) (5).

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your

receipt of this decision.

In accordance with Division rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of DWC on this

__7th__ day of _____ JUNE _____ 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: _____

**MCMC llc ▪ 88 Black Falcon Avenue, Suite 353 ▪ Boston, MA 02210 ▪ 800-227-1464 ▪ 617-375-7777 (fax)
mcman@mcman.com ▪ www.mcman.com**