



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

<b>Type of Requestor:</b> ( X ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Modern Medical Equipment 612 W. Nolana, Bldg. 100D McAllen, Texas 78504	MDR Tracking No.: M5-07-0489-01 (current MDR #) M4-05-2379-01 (former MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Rep Box # 29	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "...The peer review gave no rational for addressing medical necessity and only recommended Ben Gay and Ziplock with ice cubes, the heating pad was not some fancy devise and is exactly what the Medicare/TWCC Equipment Guidelines requires and was charged. We feel that based on her type of injury all of which have been verified by Diagnostic studies should have been covered by the insurance carrier. Peer Review 03/26/04."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a position summary to MDR,  
Principle Documentation: The Respondent did not submit a response to MDR.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due
03-19-04 to 05-19-04	E0745, E0215, E0943, L0515-LSO, E0116, E0230, E1399 and A4556	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
<b>TOTAL DUE</b>			<b>\$0.00</b>

#### 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**

28 Texas Administrative Code Sec. 133.308  
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

**PART VII: DIVISION FINDINGS AND 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:

03-15-07

\_\_\_\_\_  
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.**

March 1, 2007  
Amended: March 5, 2007

**ATTN: Program Administrator**  
Texas Department of Insurance/Workers Compensation Division  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744  
Delivered by fax: 512.804.4868

## Notice of Determination

MDR TRACKING NUMBER: M5-07-0489-01  
RE: Independent review for \_\_\_\_\_

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 1.9.07.
- Faxed request for provider records made on 1.10.07.
- TDI DWC issued an Order for Payment on 1.24.07.
- The case was assigned to a reviewer on 2.6.07.
- The reviewer rendered a determination on 2.28.07.
- The Notice of Determination was sent on 3.1.07.

The findings of the independent review are as follows:

### Questions for Review

Medical necessity of E0745-neuromuscular stimulator, E0215-electric heat pad, E0943-cervical pillow, L0515-LSO, E0116-crutch, E0230-ice cap or collar, E1399-misc DME Equip and A4556-electrodes. The dates in dispute are 3.19.04-5.19.04.

### Determination

PHMO, Inc. has performed an independent review of the disputed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **uphold the denial** on all of the disputed service(s).

### Summary of Clinical History

Ms. \_\_\_\_\_ sustained a work related on the job injury on \_\_\_\_\_, while employed with \_\_\_\_\_.

### Clinical Rationale

The medical records available do not substantiate the use in response to the treatment using these various devices, which are disputed as medically necessary. There is a letter of medical necessity, which states that the EMS is medical necessity to reduce the severe pain. It states that the EMS has been prescribed as a means to aid in the healing process and prevent re-injury when performing normal activities of daily living. This letter of medical necessity was written on \_\_\_\_\_.

On 03/19/04, a letter of medical necessity was written stating that the patient has severe pain. The patient says she has swelling down her right shoulder area. There is no documentation that the items were tried and there was improvement.

There is no peer-reviewed double-blind study in the medical literature which controls her variables and compares the use of EMS units, electric heat pads, cervical pillows, LSO, crutches, ice caps/collars, or leg wedges that demonstrates the efficacy of these devices for long-term use in the management of chronic pain. Such devices as non-electric heat pads, ice packs, and home pillows which can be fixed to a position of comfort. Because there is no evidence that the patient tried and benefited from this use, it cannot be stated by appropriate research that this is medical necessity for this particular patient.

## Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 10 years of patient care.

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The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is a diplomate of the American Board of Orthopedic Surgery, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC's list of approved providers or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and the treating and/or referring provider, 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 before referral to the IRO. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

### 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, 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.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 1<sup>st</sup> day of March, 2007. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

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Meredith Thomas  
Administrator  
Parker Healthcare Management Organization, Inc.