MDR Tracking Number: M5-03-0782-01

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 DME – supplies (hot/cold gel insert), ortho seating, spinal orthosrthosis were not medically necessary. Rental of the neuromuscular stimulator was verified paid per the requestor's representative, ___, on 3/20/03, therefore *rental DME* no longer in dispute. 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 DME 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 8/26/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 19th day of March 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

February 15, 2003

Re: IRO Case # M5-03-0782

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, Rule133.308 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 IROs, 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 Physical Medicine and Rehabilitation. 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 case, based on the medical records provided, is as follows:

History
The patient is a 29-year-old female who was injured on ___. She was moving a table when she felt an acute onset of pain in her lumbar spine radiating into both legs, groin and buttocks. On 8/2/02 she sought chiropractic care, and she then was treated extensively with chiropractic treatment, passive modalities and active exercise. An X-ray of the lumbar spine 8/9/02 was negative for fracture or significant body deformity. An MRI of the lumbar spine 9/4/02 was reportedly significant for a 1.5mm disk bulge at L4-5. An MRI of the sacrum 9/25/02 was unremarkable. The patient was prescribed various items including an airform back brace, hot/cold gel insert, obus seat cushion, obus back support, electrical stimulation unit with electrodes. The electrical stimulation unit was eventually approved by the insurance carrier.

Requested Service
DME-supplies, neuromuscular stimulator, ortho seating, spinal orthodosis (neuromuscular)stimulation unit which was eventually approved by the insurance carrier) .

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

Rationale
There is no documentation in the records presented for review justifying the need for the requested items. There is no medical evidence that the requested items are effective in the treatment of a sprain/strain. The patient has a job that requires her to stand a majority of the time. The employer has expressed a desire to modify her required activities to accommodate her pain. There is no medical necessity for a seating system, since her job

mainly requires standing. From the information presented, it is unknown why the patient needs any of this equipment.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

_____