MDR Tracking Number: M5-03-0450-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The IRO reviewed DME items rendered on 7-1-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 7, 2003, the Medical Review Division submitted via facsimile a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
7/1/02	E0781	$485.00	$287.13	M		Section	The requestor submitted

	L3670	$450.00	$139.00	M		413.011(b);	redacted audit summaries that support amount billed was fair and reasonable per Section 413.011(b); therefore, reimbursement of $508.87 is recommended. ($485.00 - $287.13 = $197.87) ($450.00 - $139.00 = $311.00)
TOTAL		$935.00					The requestor is entitled to reimbursement of **$508.87.**

This Decision is hereby issued this 7th day of July 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Order.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for date of service 7-1-02 in this dispute.

This Order is hereby issued this 7th day of July 2003.

Roy Lewis
Medical Dispute Resolution Supervisor
Medical Review Division

May 1, 2003

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: MDR #: M5-03-0450-01
IRO Certificate No.: 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant

medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Certified in Orthopedic Surgery.

Clinical History:
A male claimant underwent arthroscopic shoulder surgery on 07/01/02 due to an on-the-job injury on ___. The patient's age, details of his injury, operative findings and a full description of the surgery done were not provided.

Disputed Services:
DME on 07/01/02 (ambulatory infusion pump, cryotherapy unit—water circulating pump, wrap and pad, shoulder orthosis)

Decision:
The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the DME listed above were medically necessary in this case.

Rationale for Decision:
The provider failed to provide an operative report describing the findings and the surgical procedure carried out. Therefore, the examiner has to presume from the ICD-9 code mentioned in the surgeon's undated "letter of medical necessity", and the prescription of a post-operative orthosis (which implies an extensive injury and surgical repair) that the diagnosis is torn rotator cuff, thus justifying the DME in question.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,