MDR Tracking Number: M5-03-0837-01

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 7-2-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 June 16, 2003, the Medical Review Division submitted 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
6-28-02	L1858	$1530.00	$947.25	M	DOP	Section 413.011(b)	Provider submitted redacted EOBs from other insurance carrier's to support position that amount billed was fair and reasonable. The requestor is due the difference between amount billed and paid of $582.75.
6-28-02	97500	$150.00	$0.00	G	$27.00 / 30 min.	CPT Code description	Orthotic training report was not submitted to support billed service. No reimbursement is recommended.
7-2-02	E0781	$485.00	$263.56	M	DOP	Section 413.011(b)	Provider submitted redacted EOBs from other insurance carrier's to support position that amount billed was fair and reasonable. The

							requestor is due the difference between amount billed and paid of $221.44.
TOTAL							The requestor is entitled to reimbursement of **$804.19**

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 Decision is applicable for dates of service 6-28-02 through 7-2-02 in this dispute.

This Decision and Order is hereby issued this 26th day of August 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

January 28, 2003

Re: IRO Case # M5-03-0837

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 Orthopedic Surgery. 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 was underwent arthroscopic knee surgery on 7/2/02. He underwent partial medial and lateral meniscectomies, removal of loose bodies, limited synovectomy and chonodroplasty of the patella. Post operatively, the patient's doctor ordered the purchase of a cryotherapy device to be used for post operative treatment.

Requested Service
DME Pump for water circulating pad, Cold therapy cooler wrap, water circulating pad

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

Rationale
I would agree with the benefits of cold therapy and the use of a cryotherapy devise following arthroscopic knee surgery. However, the benefits are most therapeutic in the initial postoperative period of up to two to three weeks postop. A cryotherapy devise could be rented in this case. The documentation provided does not present an indication for long term use of the cryotherapy unit which would warrant purchase of this devise.

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

Sincerely,