MDR Tracking Number: M5-03-1578-01

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 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 the only issue** to be resolved. The DME; pain infusion pump, water circulating unit, cold therapy wrap, water circulating pad and crutches were found to be medically necessary. The DME; neuromuscular stimulator, electro-pads, supplies, training and fitting were not medically necessary. The respondent raised no other reasons for denying reimbursement for these DME charges.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 to dates of service 4/2/02 through 4/25/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 16th day of May 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

May 8, 2003

MDR Tracking #: M5-03-1578-01
IRO Certificate #:IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the «RenderedCare» to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating 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 the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient sustained a work-related injury on ___ when she injured her left knee. On 04/02/02, the patient underwent a lateral compartment arthroscopic meniscectomy of the left knee. Post-operative orders included a pain infusion pump, water circulating unit, a cold therapy wrap, a water-circulating pad, and crutches provided on 04/02/02. On 04/25/02 the patient was provided with a neuromuscular stimulator, electro-pads, supplies, training and fitting. On 05/25/02, the patient was again provided with electro-stimulator and electro-pads with supplies.

Requested Service(s)
Durable medical equipment (DME) provided from 04/02/02 through 04/25/002.

Decision
It is determined that the pain infusion pump, water circulating unit, cold therapy wrap, water circulating pad, and crutches were medically necessary to treat this patient’s condition. However, the neuromuscular stimulator, electro-pads, supplies, training and fitting were not medically necessary.

Rationale/Basis for Decision

Cold therapy is effective in helping patients with postoperative knee pain and swelling. A pain infusion pump, water-circulating unit for cold therapy, and crutches are well-accepted treatment for patients undergoing knee surgery. However, a pulse galvanic stimulator relaxation is rarely necessary for a patient who has just undergone lateral meniscectomy and synovectomy. Most patients unless they have are having significant problems in the postoperative period; do not require the treatment of a pulse galvanic stimulator. The medical record documentation does not indicate that the patient was experiencing problems that would indicate the necessity for a pulse galvanic stimulator. Therefore, the pain infusion pump, water-circulating unit, cold therapy wrap, water-circulating pad, and crutches were medically necessary to treat this patient's condition. However, the neuromuscular stimulator, electro-pads, supplies, training and fitting were not medically necessary.

Sincerely,