MDR Tracking Number: M5-03-2206-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General 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. This dispute was received on 05-05-03.

The IRO reviewed ambulatory infusion pump, pump for water circulating pad, and supplies miscellaneous DME (E1399) rendered on 05-28-02 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 for ambulatory infusion pump, pump for water circulating pad, and supplies miscellaneous DME (E1399). Consequently, the requestor is not owed a refund of the paid IRO fee.

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 08-07-03, 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
05/28/02	E0114	$110.00	42.50	F	$42.50	MFG DME GR (IX)(C)	According to 1991 MFG reimbursement for crutches is $42.50. Therefore additional reimbursement is not recommended ($42.50 was paid)
TOTAL		$110.00					The requestor is not entitled to reimbursement

This Decision is hereby issued this 17th day of March 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

July 29, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2206-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in orthopedic surgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a male who sustained a work related injury on ___. The patient underwent knee surgery in 5/28/02. The surgical procedure was indicated to be a medial and lateral compartment arthroscopic medial and lateral meniscectomy. Post surgically the patient was prescribed a cryotherapy unit to provide cold therapy for the knee.

Requested Services
Ambulatory infusion pump, pump for water circulation pad and supplies on 5/28/02.

Decision
The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision
The ___ chiropractor reviewer noted that this case concerns a male who sustained a work related injury on ___. The ___ physician reviewer also noted that the patient underwent knee surgery on 5/28/02. The ___ physician reviewer further noted that the patient was prescribed a cryotherapy unit post surgically. The ___ physician reviewer indicated that the surgery the patient underwent on 5/28/02 appeared to be a removal of two screws in the tibial tubercle. The ___ physician reviewer explained that post-operative pain for this procedure is easily managed with analgesics and application of intermittent ice. The ___ physician reviewer also explained that the literature submitted in support of the pain control system as well as cold flow therapy involves much more significant and major knee procedures.

Therefore, the ___ physician consultant concluded that the ambulatory infusion pump, pump for water circulation pad and supplies on 5/28/02 were not medically necessary to treat this patient's condition.

Sincerely,