MDR Tracking Number: M5-03-2280-01

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 supplies, pump for water circulating and ambulatory infusion pump were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these DME supply charges.

This Finding and Decision is hereby issued this 7th day of August 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

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 from 6/17/02 to 7/2/02 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 7th day of August 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 29, 2003

Re: IRO Case # M5-03-2280

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 underwent right shoulder arthroscopy, rotator cuff repair, acromioplasty, arthroscopic labral repair and capsular shrinkage. She received post-op Ultrasling, pain pump and cold therapy.

Requested Service(s)
DME supplies, pump for water circulating, ambulatory infusion pump 6/17/02 and 7/2/02

Decision
I disagree with the carrier's decision to deny the requested treatment.

Rationale
A pain pump and cold therapy are becoming the standard of care in extensive outpatient arthroscopic procedures such as this patient underwent. They reduce the need for narcotics, improve subjective patient outcomes, and are safer than traditional analgesic techniques.

An Ultrasling is a shoulder immobilizer with an abduction pillow that is critical after rotator cuff repairs to protect the repair by preventing undue tension. Based on the operative
procedure performed, these items are indicated and are medically necessary.

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

Sincerely,