MDR Tracking Number: M5-03-2282-01

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 05-02-03.

The IRO reviewed pump for water circulating pad, and miscellaneous DME equipment rendered on 05-14-02 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 pump for water circulating pad, and miscellaneous DME equipment. 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
05-14-02	E0871	$485.00	$32.34	M			E0871 is not a valid HCPCS code per the 1996 MFG. Therefore not illegible for review.
	E0114	$110.00	$40.95	M	$42.50	MFG DME GR (IX)(C)	According to 1991 MFG reimbursement for crutches is $42.50. Therefore additional reimbursement of $1.55 is recommended ($40.95 was paid)
TOTAL		$595.00					The requestor is entitled to reimbursement of **$1.55**

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 05-14-02 in this dispute.

This Decision is hereby issued this 19th day of March 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate Number: 5259
MDR Tracking Number: M5-03-2282-01

July 22, 2003

An independent review of the above-referenced case has been completed by an orthopedic physician. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
___, as a patient of ___, underwent arthroscopic assisted procedures on 5/14/03. These included an entirely arthroscopic anterior cruciate repair using a type of suture anchor and radiofrequency shrinkage of the anterior cruciate ligament. There was also a meniscectomy and lysis of adhesions that were performed. Postoperatively the patient was prescribed a cold therapy unit, specifically the Polar Care 500.

REQUESTED SERVICE (S)
Medical necessity of Polar Care Unit

DECISION
Uphold denial.

RATIONALE/BASIS FOR DECISION
There have been a couple of studies published in the pat that seem to state that Polar Care therapy can decrease the amount of postoperative narcotic usage. However, there has been only one controlled study in this arena, and this was done by Dr. Allen Barber and was funded by Orthopedic Technology, Inc., Air Cast, Inc., and Danniger Medical Technology, Inc. This procedure was also comparing the use of arthroscopically assisted patellar tendon ACL reconstruction. Certainly, this is a much more invasive and much more painful procedure in the initial 24-48 hours than the procedure done by ___. ___ basically performed an arthroscopic procedure, one small suture anchor was placed, and shrinkage was performed. Otherwise, the postoperative pain should not be much different than any type of a meniscectomy. Therefore, this was not reasonable and necessary.