MDR Tracking Number: M5-03-2295-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 May 12, 2003.

The IRO reviewed electrodes, pain management system, cold therapy cooler wrap, water circulating pad, rendered on 12/15/02 through 1/10/03 denied based upon “V”.

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.

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 August 14, 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 requestor and respondent did not submit copies of EOBs for dos 1/10/03 (L0745) therefore, the charge will be reviewed according to the DME Guidelines.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
10/25/02	L3670	$340.00	$149.57	F	DOP	MFG, Durable Medical Equipment Ground Rule (II), (IV), (IVIII), IX)	The letter of medical necessity submitted by the requestor, supports delivery of service. Therefore the requestor is entitled to additional reimbursement in the amount of $190.43.
12/15/02	E0745	$375.00	$0.00	A	$150.00	MFG, Durable Medical Equipment Ground Rule (II), (IV), (IVIII), IX) TWCC Rule 134.600 (h)(11)	Preauthorization was required & not obtained; therefore the requestor is not entitled to reimbursement of the dispute charge.
1/10/03	E0236	$494.00	$360.80	F	DOP	MFG, Durable Medical	The letter of medical necessity submitted by

						Equipment Ground Rule (II), (IV), (IVIII), IX)	the requestor, supports delivery of service. Therefore the requestor is entitled to additional reimbursement in the amount of $133.20.
	L0745	$375.00	$0.00	No EOB	$150.00	MFG, Durable Medical Equipment Ground Rule (II), (IV), (IVIII), IX)	The letter of medical necessity submitted by the requestor, supports delivery of service. Therefore the requestor is entitled to additional reimbursement in the amount of $225.00.
	L3670	$450.00	$149.57	F	DOP	MFG, Durable Medical Equipment Ground Rule (II), (IV), (IVIII), IX)	The letter of medical necessity submitted by the requestor, supports delivery of service. Therefore the requestor is entitled to additional reimbursement in the amount of $300.43.
TOTAL		$2,034.00	$659.94		$300.00		The requestor is entitled to additional reimbursement in the amount of $849.06.

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 10/25/02 through 1/10/03 in this dispute.

This Order is hereby issued this 15th day of January 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

August 7, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2295-01

___ 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 27 year-old female who sustained a work related injury on ___. The diagnosis for this patient is right carpal tunnel, traumatic arthropathy shoulder, stiffness of joint without ankylosis, bursitis shoulder, impingement syndrome shoulder. The patient has undergone an X-Ray and MRI. The patient underwent carpal tunnel release. The patient has also undergone arthroscopic debridement of the left shoulder on 1/10/03. Post surgically the patient was treated with a "pain management system" that included a constant local analgesic and fusion devies used in conjunction with a small catheter that is within the operative site. The patient also had a cold water circulation unit with its associated pad and wrap.

Requested Services

Electrodes, pain management system, cold therapy cooler wrap, water circulating pad on 12/15/99 DME code E1399, 1/10/03 DME code E0781 and E1399 times two.

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 ___ physician reviewer noted that this case concerns a 27 year-old female who sustained a work related injury on ___. The ___ physician reviewer also noted that the diagnoses for this patient included right carpal tunnel, traumatic arthropathy shoulder, stiffness of joing without ankylosis, bursitis shoulder impingement syndrome shoulder. The ___ physician reviewer further noted that the patient underwent a shoulder procedure on 1/10/03. The ___ physician reviewer explained that the procedure performed on 1/10/03 was that of an arthroscopic subacromial decompression and debridement of a partial thickness (less than 3mm) rotator cuff tear. The ___ physician reviewer noted that post surgically the patient was prescribed a pain infusion pump, Galvanic Stimulator and a cold pump. The ___ physician reviewer indicated that the surgical procedure that the patient underwent was a relatively minor procedure. The ___ physician reviewer also indicated that the arthroscopic subacromial procedure and joint exploration was

done for a case of traumatic arthropathy of the shoulder and impingement syndrome. The ___ physician reviewer noted that the operative note from 1/10/03 described a subacromial decompression and a partial rotator cuff tear with otherwise fairly normal findings in the joint. The ___ physician reviewer explained that the patient's rotator cuff tear was debrided in a limited fashion, the bone quality was excellent, there were no lose bodies and that the patient's biceps tendon, superior labrum and capsule were all normal. The ___ physician reviewer indicated that pain control for arthroscopic procedure is easily accomplished with oral analgesics, intermittent application of cold packs in the form of ice with interposed toweling on the surgical site for 30 minutes and off for 30 minutes. The ___ physician reviewer explained that the preoperative evaluation did not indicate that the there were any extenuating circumstances that would necessitate elaborate postoperative pain control. The ___ physician reviewer also explained that for arthroscopic decompressions there is no evidence in the literature that Galvanic Stimulation is indicated. Therefore, the ___ physician consultant concluded that the electrodes, pain management system, cold therapy cooler wrap, water circulating pad on 12/15/99 DME code E1399, 1/10/03 DME code E0781 and E1399 times two were not medically necessary to treat this patient's condition.

Sincerely,