MDR Tracking Number: M5-03-3084-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on July 28, 2003.

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(r)(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 ambulatory infusion pump, water circulating pump, cold therapy wrap, water circulating pad, SO acromioclavicular C, neuromuscular stimulator, electrodes, and training to apply surface neuro-stimulator were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for ambulatory infusion pump, water circulating pump, cold therapy wrap, water circulating pad, SO acromioclavicular C, neuromuscular stimulator, electrodes, and training to apply surface neuro-stimulator 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 3/3/03 through 4/30/03 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 19th day of September 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

September 17, 2003

Re: IRO Case # M5-03-3084-01

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, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. 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 had a right shoulder arthroscopy with rotator cuff repair, SLAP repair, subacromial debridement and synovectomy on 3/3/03.

Requested Service(s)
Ambulatory infusion pump, water circulating pump, cold therapy wrap, water circulating pad, SO acromioclavicular C, neuromuscular stimulator, electrodes, and training to apply surface neurostimulator 3/3/02 – 4/30/02.

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

Rationale
The requested services are becoming the standard of care after outpatient shoulder surgery. They reduce the need for narcotic use, and increase patient comfort, thereby facilitating patient recovery. This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,