

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.

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. It was determined that the water circulating unit, cold therapy wrap, water circulation pad and auto adapter were medically necessary. The respondent raised no other reasons for denying reimbursement for the durable medical equipment.

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 date of service October 24, 2001 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 13th day of, May 2002.

Marguerite Foster,
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

NOTICE OF INDEPENDENT REVIEW DECISION

March 25, 2002

David Martinez
Chief, Medical Dispute Resolution
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 40
Austin, TX 78704-7491

RE: Injured Worker:
MDR Tracking #: M5-02-1948-01
IRO Certificate #: 4326

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a _____ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The _____ physician reviewer has signed a certification statement stating 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 the referral to _____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

The _____ physician reviewer has determined that the rendered care was medically necessary for treatment of the patient's condition. Therefore, _____ disagrees with the previous adverse determination. The specific reasons including the clinical basis for this determination are as follows:

This 31-year-old male sustained a lumbar injury when he was carrying a heavy box in _____. The medical record documentation presents a clinical history of pain related to chronic lumbar disc disease/sprain/strain, with documentation of relatively continuous back spasms, spine fixation, and decreased motions since shortly after the date of injury. Following surgery (intradiscal electrothermal disc decompression nucleotomy and annuloplasty at L4-L5) on 10/25/01, the surgeon prescribed a water circulating pad and a cold therapy cooler wrap. The use of cold/cooling may relieve or reduce pain and discomfort in such situations. The cooling effect of ice packs is relatively brief and the cooling effect of the prescribed water-circulating pad is more sustaining. These modalities are valuable in chronic or acute conditions. Therefore, it is determined that the water circulating unit, cold therapy wrap, water circulation pad and auto adapter were medically necessary to treat this patient's condition.

Sincerely,

Director of Medical Assessment