THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-1659.M5

MDR Tracking Number: M5-02-1951-01

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 received a withdrawal on date of service 11/1/01 for the CPT code E13993, therefore, the only issues remaining are medical necessity issues.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Per the Requestor, the Respondent reimbursed the IRO fee on 4/22/01. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission does not have to order the respondent and non-prevailing party to **refund the requestor** 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. The Durable Medical Equipment (DME), pad and pump for water circulating pad, were found to be medically necessary. The respondent raised no other reasons for denying reimbursement charges for the (DME), pad and pump for water circulating pad.

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 11/6/01 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 18th day of November 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

April 1, 2002

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

Attention: Margaret Q. Ojeda

Re: Medical Dispute Resolution
MDR #: M5-02-1951-01
IRO Certificate No.: IRO 5055

Dear Ms. Ojeda:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a Physician Board Certified in Neurology and Pain Management.

THE PHYSICIAN REVIEWER OF THIS CASE DISAGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning Case File #M5-02-1951-01, in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution request.
2. Medical Audit dated 12/31/01 by ___.
3. "Exhibit 1" dated 3/05/02.
4. Pre-authorization dated 11/02/01.
5. Clinic note from ___, dated 10/18/01.
6. CT scan of the right calcaneus dated 10/19/01.
7. Consultation note by ___, dated 10/29/01.
8. Pre-procedure orders by ___, dated 11/01/01.
9. ___ clinic note dated 11/14/01.
10. Operative report dated 11/06/01.
11. Discharge summary dated 11/10/01.
12. Product description by ___, regarding IsoComforter cold therapy water circulating unit.

B. SUMMARY OF EVENTS:

The claimant sustained a right calcaneus fracture after falling off a ladder, with a work-related date of injury being ___. The fracture was treated with open reduction and internal fixation on 11/06/01, by ___. Pre-operative orders clearly indicated that ___ had requested the cold therapy cooler with ankle wrap to be delivered on the day of surgery for use. The first postoperative note dated 11/14/01 indicates that the patient was recovering well at that point, with "very little pain" in the foot and "very little swelling" on exam.

C. OPINION:

I DISAGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

I base this on the fact that the surgeon, ___ clearly ordered this treatment pre-operatively, for use immediately after the operation on the day of surgery.

The device was used for treatment, presumably as ordered by the surgeon, with no evidence presented that this therapy was denied prior to its use. Additionally, it is clear, in the first postoperative note, that the patient had very little pain and swelling from the operation, indicating that the device did offer benefit.

The product description, provided by ___, does address the issue of this device compared to cold packs, and I believe that the issues described are pertinent in regards to the dangers of frostbite, etc. Though there is no doubt that this device ended up being much more expensive compared to "cold-pack" therapy, it does appear to have provided effectiveness and value to the patient in his recovery, without exposing this patient to the risks as well as discomfort that can be experienced with typical cold-pack therapy.

The most compelling reason to approve payment for this service is the fact that the treating surgeon clearly ordered this device pre-operatively, for use immediately after the surgery, and his judgment for the use of this device should be respected. If it is felt, administratively, that this device should not be utilized in place of conventional cold-pack therapy, this decision should certainly be made prior to the surgery and made clear to the surgeon and the company supplying the service, prior to the date of the surgical procedure.

D. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

_____

Date: 29 March 2002