

MDR Tracking Number: M5-02-2026-01

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 has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the Commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

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 not the only issue to be resolved. The durable medical equipment provided on 5-22-01 was found to be medically necessary. There is still an unresolved fee dispute for the durable medical equipment provided on 6-4-01.

Based on Commission Rule 133.307(g)(3), the Division notified the requestor on 11-14-02 to provide two copies of additional documentation relevant to the fee dispute. The insurance carrier signature page was signed for on 11-14-02. The requestor did not respond to the request for additional documentation. The respondent did not submit a response to the request. The “No Response Submitted” sheet is reflected as Exhibit #2 in the dispute file.

Notice of Medical Dispute is reflected as Exhibit #3 of the Commission’s case file.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
5-22-01	E0236	\$494.00	0.00	U	DOP	IRO Decision §133.1(a)(8)	The IRO determined this DME was medically necessary. The carrier did not object to the fair and reasonable reimbursement; therefore, reimbursement is recommended as billed, \$494.00 .
5-22-01	E1399	\$ 75.00	0.00	U	DOP		Rationale same as above. Therefore, reimbursement is recommended as billed, \$75.00 .
5-22-01	E1399	\$155.00	0.00	U	DOP		Rationale same as above. Therefore, reimbursement is recommended as billed, \$155.00 .

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
5-22-01	E1399	\$ 45.00	0.00	U	DOP		Rationale same as above. Therefore, reimbursement is recommended as billed, \$45.00.
6-4-01	E0748	\$5000.00	\$3,342.55	M	DOP	96 MFG DME GR	No documentation was submitted to support additional reimbursement.
6-4-01	97139	\$185.00	0.00	G	DOP	96 MFG Medicine GR I.C. 1.q.	No documentation was submitted to support reimbursement.
TOTAL		\$5,954.00	\$3,242.55				The requestor is entitled to reimbursement of \$769.00.

On this basis, the total amount recommended for reimbursement (\$769.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay \$769.00 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 5-22-01 through 6-4-01 in this dispute.

This Order is hereby issued this 24th day of January 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

April 18, 2002

Re: IRO Case # M5-02-2026-01

Texas Workers' 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 IRO's, 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 Neurological Surgery. 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 ___ reviewer who reviewed this case has determined that, based on the medical records provided, the requested care was medically necessary. Therefore, ___ disagrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

This case involves a 42-year-old male who on ___ fell when a ladder "gave way." He developed pain in his back which extended into the lower extremity, with some numbness in the lower extremity. An MRI of the lumbar spine showed severe degenerative joint disease change, along with a herniated disc, and a slight retrolisthesis at the L5-S1 level. Because of the patient's persistent difficulty despite physical therapy and epidural steroid injections, the patient was taken to surgery 5/24/01, where a "360 degree" procedure at the L5-s1 level was carried out. Anterior lumbar interbody fusion along with pedicle

screw placement was included in the operation. Postoperatively, on 6/14/01 persistent pain was noted in the patient's back. A water-circulating unit with cooler wrap and cooler pad was recommended. It was thought that this device would also improve wound healing. I disagree with the carrier's decision to deny this patient the requested water circulating unit with cooler wrap and cooler pad. Under the circumstances of the major surgery that the patient underwent, his use of cold packs on his own would probably be inadequate. In addition, there is little debate that cryotherapy may be significantly beneficial, and the most efficient way of obtaining the benefit would be with the device that was ordered by___.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of proceedings, Texas Worker's Compensation Commission, P O Box 4066, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,
