MDR Tracking Number: M5-02-2171-01

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 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. 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 not the only issue** to be resolved. The water circulating unit, cold therapy cooler wrap, water circulating pad, and auto adapter were found to be medically necessary. The respondent also raised medical fee issues for the osteogenesis stimulator charges.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimburs e-ment)	Reference	Rationale
11-15-01	E0236 E1399 E1399 E1399	$494.00 $75.00 $155.00 $45.00	$ -0- $ -0- $ -0- $ -0-	U	DOP	IRO Decision § 413.011 §133.1(a)(8)	I The IRO determined these DME items were medically necessary to treat this patient's condition. The denial reason only addressed medical necessity. The MAR for these DME items is based on DOP. Since the amount of reimbursement was not raised, recommended reimbursement as billed. $494.00 + $75.00 + $155.00 + $45.00 = $769.00.
11-27-01	E0748	$5,000.00	$3,579.91	M	DOP	MFG DME GR § 413.011 §133.1(a)(8)	a The carrier initially reimbursed the requestor $3,342.55 and upon review of the additional documentation, agreed to reimburse an additional $227.35 plus interest for a total reimbursement of $3,579.91. See RATIONALE below. Recommend additional

							reimbursement of $1,420.09.
TOTAL		$5,769.00	$3,579.91				The requestor is entitled to additional reimbursement of $2,189.09.

RATIONALE

The insurance carrier indicates their method of fair and reasonable reimbursement is based on the 2001 Region C DMEPOS Fee Schedule. At the time the DME was billed, the 1996 MFG was in effect. The DME ground rules state that DME items should be billed at the usual and customary rate of the DME provider and that the insurance carrier will reimburse at a pre-negotiated amount or the fair and reasonable amount if there is no pre-negotiated amount. The requestor submitted redacted EOBs that showed the same DME billed where another carrier paid the full amount billed. This meets the requirements of the Texas Labor Code § 413.011. Therefore, additional reimbursement of $1,420.09 is recommended for the osteogenesis stimulator.

The above Findings and Decision are hereby issued this 27th day of December 2002.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 11-15-01 through 11-27-01 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 per Rule 133.307(j)(2).

This Order is hereby issued this 27th day of December 2002.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dzt

NOTICE OF INDEPENDENT REVIEW DECISION

August 9, 2002

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-02-2171-01
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.

Clinical History

This 51 year old female sustained a work related injury on ___ when she was moving boxes and experienced low back pain radiating down to her legs. On 11/15/01 the patient underwent lumbar discectomy with interbody fusion. Post-operatively, the patient was prescribed cold therapy and the equipment included a water circulating unit, cold therapy cooler wrap, water circulating pad, and auto adapter.

Requested Service(s)

Water circulating unit, cold therapy cooler wrap, water circulating pad, and auto adapter.

Decision

It is determined that the water circulating unit, cold therapy cooler wrap, water circulating pad, and auto adapter are medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Cryotherapy is beneficial in relieving pain. The patient had significant spinal surgery and the use of cold therapy in this case is reasonable. Cold packs may be used for a similar purpose; however, there are problems with cold packs that are alleviated by the use of cold therapy devices. Problems with cold packs may include: more intensive care and supervision with placement and replacement of the packs, impaired patient mobility and possible increased patient discomfort associated with repeated cold pack application. Therefore, the water circulating unit, cold therapy cooler wrap, water circulating pad, and auto adapter are medically necessary.

Sincerely,