

MDR Tracking Number: M5-02-2267-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 2-7-02.

The Medical Review Division has reviewed the enclosed 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)(2)(C), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** 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.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
2/15/01	ASC 23410	\$6,400.00	\$6,400.00	F	Fair & reasonable	NA	Paid
2/15/01	ASC 29826	\$6,200.00	\$ 0.00	T, G	Fair & reasonable	IRO decision	The IRO determined that the shoulder arthroscopy and related procedures were medically necessary. The carrier did not object to fair and reasonable reimbursement; therefore, reimbursement is recommended as billed - \$6,200.00.
2/15/01	ASC 29823	\$5,200.00	\$2,600.00	F	Fair & reasonable	§133.1(a) (8) §413.011 (b)	The requestor submitted documentation to support service rendered. The requestor submitted documentation to support additional reimbursement. See RATIONALE below. Recommend additional

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
							reimbursement of \$2,600.00.
2/15/01	ASC 23700	\$2,200.00	\$ 0.00	T, G	Fair & reasonable	IRO decision	The IRO determined that the shoulder arthroscopy and related procedures were medically necessary. The carrier did not object to fair and reasonable reimbursement. Method of payment for primary and secondary procedures is not applicable to ambulatory surgical centers. Therefore, reimbursement is recommended as billed – \$2,200.00.
2/15/01	ASC Pharmacy & Anes.	\$ 895.00	\$ 0.00	T, G	Fair & reasonable	IRO decision	The IRO determined that the shoulder arthroscopy and related procedures were medically necessary. The carrier did not object to fair and reasonable reimbursement; therefore, reimbursement is recommended as billed - \$895.00.
TOTAL		\$20,895.00	\$9,000.00				The requestor is entitled to reimbursement of \$11,895.00.

RATIONALE: Per Rule 133.307(g)(3)(D), the requestor provided documentation to discuss, demonstrate, and justify additional reimbursement. The requestor provided redacted EOBs for similar operative services where the bills were paid @ 100%. Per Rule 134.1, the respondent submitted a response but did not include a reasonable explanation to determine fair and reasonable reimbursement for the portion of the bill it paid @ 50% of the billed amount. The respondent's explanation on the EOB stated it paid 100% of charges for primary procedure and 50% for secondary. The disputed services were performed in an ambulatory surgical center for which there is no medical fee guideline; therefore, the method of payment for primary and secondary procedures referenced here would not apply.

The above Findings and Decision are hereby issued this 7th day of October 2003.

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 date of service 2/15/01 in this dispute.

This Order is hereby issued this 7th day of October 2003.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division

DRM/dzt

January 8, 2003

Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR#: M5-02-2267-01
IRO Certificate No.: IRO 5055

Dear:

___ 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 who is Board Certified in Chiropractic medicine.

Clinical History:

This female claimant suffered a shoulder injury on her job on _____. She initially underwent a shoulder arthroscopy, with failure to improve, and, subsequently a second procedure with rotator cuff repair. Other than for loss of range of motion, the patient seems to have done well.

Disputed Services:

Shoulder arthroscopy, fixation of shoulder, and related pharmacy charges.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the requested procedures and medications were medically necessary in this case.

Rationale for Decision:

It is clear from the records provided that these procedures and related pharmacy charges were medically necessary. The patient has undergone conservative care to the injured shoulder. An MRI confirmed the findings on examination, and hence, the cause of treatment has been appropriate. Conservative care has failed. The objective findings on the imaging studies confirm the patient's complaints. It is clear that this particular surgery was reasonable and medically necessary.

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 who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,