

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 the only issue** to be resolved. The pump for water circulating pad and supplies were found to not be medically necessary. The respondent raised no other reasons for denying reimbursement charges for the pump for water circulating pad and supplies.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
2/18/02	E0236 E1399 E1399	494.00 75.00 155.00	0.00	U	DOP	IRO decision	The IRO determined this DME was not medically necessary and therefore not reimbursable.
2/18/02	E0781 E0114	485.00 110.00	252.64 39.26	M	DOP	§133.1(a)(8)	The requestor was requested to submit two copies of medical documentation on 8/9/02 and 9/27/02 for completing the fee component of this dispute. The documentation has not been received and the timeframe has expired, therefore, no reimbursement recommended.
TOTAL		\$1319.00					The requestor is not entitled to reimbursement.

«MDR»

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On this basis, therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, reimbursement for date of service 2/18/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 28th day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

July 9, 2002

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

RE: MDR Tracking #: M5-02-2503-01
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 male sustained an on-the-job injury to his right knee on _____. The diagnostic impression was internal derangement and the patient underwent multiple arthroscopic procedures on his right knee on 02/18/02. Post-operative knee rehabilitation included physical therapy, CPM machine and therapy with the cold circulating unit/wrap/pad.

Requested Service(s)

Cold Circulating Unit, Wrap and Pad

Decision

It has been determined that the cold circulating unit, wrap and pad were not medically necessary.

Rationale/Basis for Decision

The documentation presented for review did not include the medical history of this patient's injury, a complete physical examination or diagnostic test results such as an MRI. In addition, the details of the surgical procedures were not explained. While cryotherapy has been demonstrated to be of benefit in the immediate post-operative period after total knee replacement, the effectiveness for arthroscopic procedures has not been demonstrated. Therefore, based on the documentation submitted for review, the cold circulating unit, wrap and pad were not medically necessary.

Sincerely,