

MDR Tracking Number: M5-02-2525-01

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. There are unresolved fee issues.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
6/12/01	L0565 E1399 E1399	\$495.00 \$250.00 \$139.00	0.00	U	DOP	IRO Decision	The IRO determined this DME was not medically necessary; therefore, no reimbursement is recommended.
6/13/01	E1399 E1399	\$190.00 \$ 60.00	0.00	U			
6/14/01	E1399 (D0345) E0199	\$125.00 \$120.00	0.00	U			
5/24/01	E1399 (Large Turtle Pack) E1399 (1 liter Coats Aloe) E 1399 (Stimprene Elec. Gar)	\$179.90 \$ 54.73 \$495.00	0.00	N	DOP	96 MFG DME GR IV, IX §413.011(b)	Documentation submitted included a generic statement of medical necessity for products prescribed; however, the rule requires a statement to address the diagnosis, prognosis, and expected duration the

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
							equipment/supplies will be required. A letter dated 2-28-02 to the insurance carrier did address the diagnosis and prognosis but not the expected duration of the equipment/supplies. Code E1399 requires an exact description of procedure/service, nature, extent and need for procedure/service, time and skill level necessary for procedure/service and any other pertinent information. DME order form dated 5-24-01 supports a request for a large turtle pack, aloe liniment and stimprene garment; however, there was no documentation to support the DOP requirements. The information sheets on the three products are generic in nature. No additional reimbursement recommended.
TOTAL		\$7,526.90	0.00				The requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 11th day of April 2003.

Dee Z. Torres
 Medical Dispute Resolution Officer
 Medical Review Division

DZT/dzt

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

February 4, 2003

Re: IRO Case # M5-02-2525

Texas Worker's 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 IROs, 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 Physical Medicine and Rehabilitation. 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 determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 32-year-old male who injured his back on ___. While lifting an air conditioning unit with another person he felt a tearing and popping in his back. He had acute onset low back pain which radiated down his left thigh. He was taken to the ER and an MRI was obtained. The MRI was significant for a central disk protrusion at L5-S1. The patient received chiropractic treatment and was evaluated by an M.D. who prescribed medication and durable medical equipment for the patient's low back pain.

Requested Service

6/12/01 L0565 Body Jacket, E1399 Genie Massager, E1399 Asso Kit Genie Massager,

6/13/01 E1399 Ombus Form Cush, E1399 Leg Spacer,
6/14/01 E1399 D0345Lg Therm Heat Pad, E0199 Egg Crate Mattress

Decision

I agree with the carrier's decision to deny the requested equipment.

Rationale

No documentation was presented to support the medical necessity of the requested items. There is no documentation in the clinical notes provided describing why these items are necessary or describing any benefit from the use of these items. There is no scientific basis for use of this equipment by the patient. The literature supplied by the vendor does not support any scientific basis for use of these items. The patient was observed by his supervisor having no difficulties getting in and out of a car, and was able to work in his yard and garden at home. If DME was required for the patient, there are more cost effective alternatives to be used.

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

Sincerely,