

MDR Tracking Number: M5-02-2559-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the water circulating pump, pad and miscellaneous durable medical equipment rendered were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that water circulating pump, pad and miscellaneous durable medical equipment fees were the only fees involved in the medical dispute to be resolved. As the treatment, (water circulating pump, pad and miscellaneous durable medical equipment) was not found to be medically necessary, reimbursement for date of service 5/16/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 19th day of November 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

November 18, 2002

Re: Medical Dispute Resolution
MDR #: M5.02.2559.01
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 certified in Orthopedic Surgery.

Clinical History:

This 25-year-old man suffered left femoral shaft fractures as a result of an injury on _____. He was treated with open reduction and internal fixation, and had the hardware removed on 05/16/01. Imaging studies prior to the 05/16/01 surgery revealed a healed subtrochanteric fracture of the left femur with an intramedullary nail with fixation screws into the neck and head of the femur, and two distal locking screws.

Disputed Services:

Water circulating pump, pad and miscellaneous durable medical equipment.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the equipment in question is not medically necessary in this case.

Rationale for Decision:

While cryotherapy is widely used as a treatment for acute joint injuries and postoperatively, especially for anterior cruciate ligament reconstruction, and has been shown to have some advantages after total knee arthroplasty, it is not routinely required after lower limb surgery, as in this case. Even in the cases for which its use is justified, it is generally prescribed for the immediate postoperative or short-term period and would not require purchase, especially in view of the diagnoses in this case.

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 or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,