

MDR Tracking Number: M5-02-2634-01

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. The respondent also raised medical fee issues to be resolved.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
11/21/01	E1399	\$125.00	\$ 39.95	M	DOP	DME GR IV, IX §413.011(b)	DME ground rules state that a fair and reasonable reimbursement shall be the same as the fees set for the "D" codes in the '91 MFG. E0930 corresponds to "D" code D0531 that rents for \$67.50. Recommend additional reimbursement of \$42.50.
11/21/01	E1399	\$215.00	\$ 59.95	M	DOP	DME GR IV, IX §413.011(b)	DME ground rules state that a fair and reasonable reimbursement shall be the same as the fees set for the "D" codes in the '91 MFG. E1399 – back brace, corresponds to "D" code D0523 for \$49.95. No additional reimbursement is recommended.
11/21/01	L1499	\$ 50.00	0.00	G	DOP	DME GR IV, IX	L1499 Unlisted procedure for spinal stenosis (hot/cold gel insert pad) was denied as "G – global". The global concept is only addressed in the MFG Surgery Section. Carrier states this hot/cold pad is included in the cost of the back brace, D0523. Description of D0523 states, "lumbar brace, elastic w/stays (other than custom fitted)". Documentation does not

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
							support order for this item. No reimbursement is recommended.
3/13/02	E0236 NU	\$494.00	0.00	U	DOP	IRO Decision	The IRO determined this DME was medically necessary. Since the carrier disputed the fair and reasonable amount, the requestor submitted redacted EOBs to show the average reimbursement to be 96.66%; therefore, recommended reimbursement of \$477.50.
3/13/02	E1399	\$ 75.00	0.00	U	DOP	IRO Decision	The IRO determined this DME was medically necessary. Since the carrier disputed the fair and reasonable amount, the requestor submitted redacted EOBs to show the average reimbursement to be 100%; recommend reimbursement of \$ 75.00.
3/13/02	E1399	\$155.00	0.00	U	DOP	IRO Decision	The IRO determined this DME was medically necessary. Since the carrier disputed the fair and reasonable amount, the requestor submitted redacted EOBs to show the average reimbursement to be 100%; recommended reimbursement of \$155.00.
3/13/02	L0430	\$1800.00	\$1,215.38	M	DOP	DME GR IV, IX §413.011(b)	See RATIONALE below. Recommend additional reimbursement of \$584.62.
3/13/02	L0510	\$300.00	0.00	N	DOP	DME GR IV, IX	Documentation submitted included a statement of medical necessity for a custom corset; however, it was a generic statement for patients recovering from back surgery. The statement did not address the claimant's diagnosis, prognosis, and the expected duration the equipment will be required. Therefore, no reimbursement is recommended.
3/13/02	E0143	\$121.55	\$ 35.00	M	DOP	DME GR IV, IX §413.011(b)	DME ground rules state that a fair and reasonable reimbursement shall be the same as the fees set for the "D" codes in the '91 MFG. E0143 corresponds to "D" code D0634 that rents for \$35.00. No additional reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
3/13/02	E1399	\$112.00	\$ 24.95	M	DOP	DME GR IV, IX §413.011(b)	Code E1399 requires a 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 2-26-02 supports a request for a shower head extension; however, there was no documentation to support DOP requirements. No additional reimbursement recommended.
3/13/02	E0930	\$ 67.50	\$ 25.00	M	DOP	DME GR IV, IX §413.011(b)	DME ground rules state that a fair and reasonable reimbursement shall be the same as the fees set for the "D" codes in the '91 MFG. E0930 corresponds to "D" code D0531 that rents for \$67.50. Recommend additional reimbursement of \$42.50.
3/15/02	E0748	\$5,000.00	\$3,487.02	M	DOP	DME GR IV, IX §413.011(b)	See RATIONALE below. Recommend additional reimbursement of \$1,512.98.
TOTAL		\$8,515.05	\$4,887.25				The requestor is entitled to reimbursement of \$2,890.10 .

RATIONALE

The insurance carrier indicates their method of fair and reasonable reimbursement is based on the 2002 Region C DMEPOS Fee Schedule. At the time the DME was billed, the 1996 MFG was still 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 for E0748, bone growth stimulator, and L0430, TLSO brace that show the same DME billed to another carrier who paid the full amount billed. This meets the requirements of the Texas Labor Code § 413.011. Therefore, additional reimbursement of \$1,512.98 is recommended for the bone growth stimulator and an additional \$584.62 is recommended for the TLSO brace.

Consequently, the Commission has determined that **the requestor prevailed** on the majority of the medical fees \$2,890.10. 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.

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

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay \$3,540.10 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 11-21-01 through 3-15-02 in this dispute.

This Order is hereby issued this 11th day of March 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dzt

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 22, 2002

Re: IRO Case # M5-02-2634-01

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 IRO's, TWCC assigned this case to ___ Envoy 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 ___ reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment was medically necessary. Therefore, ___ disagrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

History

This case involves a 42-year-old female who injured her back ____. She developed pain in her low back which radiated into the left buttock and left thigh. She was treated conservatively without benefit. Diagnostic testing and imaging showed problems at L5-S1 and L2-3. A 360 degree fusion was performed at L5-S1 on 3/20/02. The post operative equipment recommended included cold water therapy equipment and an airform back brace and gel insert.

Requested Service(s)

ED 236, E1399 (x2), L1499

Decision

I disagree with the carrier's decision to deny the requested equipment for the cold water circulating unit, and gel insert for the PLSO.

Rationale

Cold water therapy is a proven treatment to reduce pain and improve mobility. It is also effective in reducing post-operative pain, stiffness and swelling. The benefit of cryotherapy is that it presents no danger of tissue damage from prolonged exposure, unlike cold packs. With cryotherapy the patient can undergo treatment for a longer time, and the requested equipment

facilitates the treatment. Foam gel inserts are shown to be appropriate and necessary for improved fit and compliance with use of a brace by the patient.

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

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,