

MDR Tracking Number: M5-03-0926-01

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 pump water circulating pad and DME supplies were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that the pump water circulating pad and DME supply fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for date of service 9/3/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 11th day of April 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

April 3, 2003

Re: Medical Dispute Resolution
MDR #: M5.03.0926.01

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 Orthopedic Surgery.

Clinical History:

The vague history provided regarding this female claimant was found in the physician's letter of medical necessity dated 11/01/02, in which he states, "...she sustained a left elbow injury."

Disputed Services:

Water circulating pump, water circulating pad, and cold therapy wrap.

Decision:

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

Rationale for Decision:

No evidence was found in the material provided to support the necessity of the DME in question. The usefulness of circulating cold therapy is well established for knee anterior cruciate ligament reconstruction, and occasionally in other joint reconstructive procedures. However, its use is questionable in the majority of orthopedic surgery cases.

The series of articles provided by the requestor supporting the use of cold therapy dealt with ACL reconstruction and cold compression in athletes with sports injuries. Again, the records provided contained no detailed description of this patient's injury or surgery, thus providing no evidence to support the necessity of the DME in question.

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,