

MDR Tracking Number: M5-03-1951-01

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 and determined that **the requestor prevailed** on the issues of medical necessity. 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 \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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 DME treatments rendered post shoulder surgery were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these DME treatment charges.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) 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 4/29/02 through 11/12/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 17th day of July 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

July 14, 2003

Re: Medical Dispute Resolution
MDR #: M5-03-1951-01
IRO Certificate No.: IRO 5055

___ 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 female patient injured her left shoulder in a work-related accident on ____. She underwent two arthroscopic surgical repairs, one on 04/29/02, and one on 11/12/02. The first procedure included a rotator cuff repair, repair of torn labrum for glenohumeral instability, partial resection of the acromioclavicular joint (arcomioplasty), and tenodesis of the ruptured biceps long-head tendon.

The second procedure included intra- and extra-articular debridement for scarring and adhesions. After each of the procedures, the surgeon inserted a wound catheter for an ambulatory infusion pump for post-operative pain management, and a cryotherapy unit (water circulating pump w/wrap and pad) also for pain control. He also prescribed a shoulder immobilizer ("UltraSling II").

Disputed Services:

DME treatments rendered from 04/29/02 through 11/12/02.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the DME treatments in question were medically necessary in this case.

Rationale:

Some would consider these three DME devices excessive and unnecessary; however, many orthopedic surgeons would agree it is appropriate therapy. These devices are a routine protocol in this surgeon's management of pain following shoulder surgery.

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,