

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Lonestar DME 1509 Falcon Drive Suite 108 Desoto, Texas 75115	MDR Tracking No.: M5-05-2342-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Indemnity Insurance Co Box 15	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
02-14-05	02-14-05	E0731 (glove, elbow and shoulder garments)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Authorized Signature

Typed Name

06-13-05

Date of Decision

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: 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/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-2342-01
Name of Patient:	
Name of URA/Payer:	Lonestar DME
Name of Provider: (ER, Hospital, or Other Facility)	Lonestar DME
Name of Physician: (Treating or Requesting)	Jeff Rodriguez, DC

June 10, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

June 10, 2005

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Very limited information provided suggests that this patient was prescribed conductive garments for the right shoulder, right wrist and right elbow by a Dr. Jerry Franz (specialty unknown) on 02/04/05 for an injury that occurred _____. No specifics of the injury are provided for review. The patient is apparently seen by a Bruce Byrne, MD, on 04/01/05 indicating a diagnosis of cubital tunnel, DeQuervains, scapholunate pain and elbow ligament sprain. Physical therapy appears to be ordered for 2-3x per week for 4 weeks but no mention is made of conductive glove garments prescribed by Dr. Franz. The patient also appears to be seen by a Jeff Rodriguez, DC, but no reports from this evaluation are provided for review. In addition, no reports, clinical rational, diagnosis or specific medical necessity for these items are provided by Dr. Franz (ordering doctor).

REQUESTED SERVICE(S)

Determine medical necessity for E0731 glove, elbow and shoulder garment(s) for date of dispute 02/14/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Medical necessity for these DME items (E0731 glove, elbow and shoulder garment(s)). **are not supported** by available documentation. This file contains no specific clinical rationale or projected therapeutic benefit for these items as prescribed. In addition, ordering doctor is not clearly identified, and no clinical assessment appears provided by his report.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.