

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

| | |
|---|--|
| Type of Requestor: (X) HCP () IE () IC | Response Timely Filed? () Yes (X) No |
| Requestor's Name and Address Lonestar DME 1509 Falcon Drive Suite 106 Desoto, Texas 75115 | MDR Tracking No.: M5-05-2393-01 |
| | TWCC No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address Liberty Insurance Corp, Box 28 | Date of Injury: |
| | Employer's Name: |
| | Insurance Carrier's No.: |

PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY SERVICES

| Dates of Service | | CPT Code(s) or Description | Did Requestor Prevail? |
|------------------|---------|----------------------------|---|
| From | To | | |
| 1-17-05 | 1-17-05 | whirlpool and biofreeze | <input checked="" 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 **prevailed** on the disputed medical necessity issues. Per Rule 134.202 (c)(6) "For products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature

Typed Name

7-28-05
Date of Order

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.

NOTICE OF INDEPENDENT REVIEW DECISION

July 20, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking # M5-05-2383-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating 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 the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This female patient injured her right elbow on ___ in a work related event. She has been treated with medications, therapy, and nerve blocks.

Requested Service(s)

Whirlpool and bio freeze for date of service 01/17/05

Decision

It is determined that there is medical necessity for the whirlpool and bio freeze for date of service 01/17/05 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient received therapy, medication and nerve blocks to treat her injury. Her physician also prescribed whirlpool and bio freeze therapy to utilize at home as a part of her ongoing treatment. National treatment guidelines allow for this type of treatment for this type of injury and there is sufficient documentation to clinically justify the use of this equipment. Therefore, the whirlpool and bio freeze for date of service 01/17/05 is medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-2383-01

Information Submitted by Requestor:

- Claims

Information Submitted by Respondent:

- Durable Medical Equipment
- Progress Notes
- Diagnostic Tests
- Designated Doctor Impairment Rating