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.: M5-05-2505-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Hartford Underwriters Insurance Box 27	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**		
01-04-05	**01-04-05**	**E0217-NU and E0731-NU**	☒ **Yes** ☐ **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. The amount of reimbursement due from the carrier for the medical necessity issues equals **$853.16.**

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 totaling $853.16 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.

Findings and Decision and Order By:

		08-10-05
Authorized Signature		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

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

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

[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:	M5-05-2505-01
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)	Marivel Subia, DC

August 9, 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.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY
Available documentation received and included for review consists of records from multiple providers including: Marivel Subia, DC; Andrew Small, MD; Robert Ippolito, MD; Michael Muncy, MD; Susan Erredge, DPM; James Garrison, MD; Martha Walkup, DO; Felicia Hernandez, MA, LPC, Lonestar DME; MRI and CT scans, left foot, Electrodiagnostics from Neuroscience Centers (Jonathan Walker, MD).

Ms. ___, a 48 year-old female sustained a work-related injury on ___ while working as a day porter for . An overhead metal freight elevator door fell onto her right foot, landing primarily on the MP joint of the great toe. Initially diagnosed as a crush injury, MRI revealed a bone contusion. She went through extensive PT with Dr. Subia, a chiropractor with symptomatic relief, but no longstanding improvement. Medication (Ultracet, Ultram) was consistently prescribed through Dr. Small, and injections of Kenalog into the right foot were administered per Dr. Ippolito (12/09/04) for a diagnosis of peroneal nerve compression in the right foot.

A Designated Doctor (Erredge) recommended surgical consult for decompression / dennervation of the sensory branch of the right deep peroneal nerve on 01/24/05.

A prescription for a water circulating heat pad and form-fitting e-stim garment has been recommended.

This has been denied for payment based on medical necessity and is thus referred for medical dispute resolution purposes through the IRO process.

REQUESTED SERVICE(S)
E0217NU-water circulating pump; E0731NU-Form fit conductive garment.

DECISION
Approved.

RATIONALE/BASIS FOR DECISION
The documentation demonstrates that the patient continues with a pain level of between 4-5/10, with continued clinical evidence of motion loss, tenderness and swelling of the right foot area.

A trial of care has been documented with a rental period, and this form of therapy has been employed with success in the patient's care regime in that it has provided for some pain relief and impact to improve her activities of daily living.

As such, it satisfies the standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits):

'an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.'

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:
Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".
Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;
Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.
Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140