



**Texas Department of Insurance, Division of Workers' Compensation**  
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION**  
**Retrospective Medical Necessity and Fee Dispute**

**PART I: GENERAL INFORMATION**

<b>Type of Requestor:</b> <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Lonestar DME 1509 Falcon Drive Suite 106 Desoto, Texas 75115	MDR Tracking No.: M5-05-2590-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

**PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

DOCUMENTATION SUBMITTED: DWC-60 package, CMS 1500s and explanations of benefits

POSITION SUMMARY: "at this time I respectfully request that your office assign and IRO, and when the requestor prevails enter a Decision & Findings citing that Lonestar DME is entitled to payment under Labor code 408.021, as well as the claimant is entitled to treatment under Labor Code 408.021. I also ask that office review this file for any interest and/or penalties under Rule 134.803, proving to Texas Mutual, that the Rules adopted by your agency are established for all of us to follow and we all must adhere to them".

**PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: No position summary submitted by Respondent

**PART IV: SUMMARY OF DISPUTE AND FINDINGS**

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
01-24-05 & 03-18-05	E1399 (biofreeze and therapy ball)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$45.00
01-24-05	E0731 (conductive garment)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

**PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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 **majority** of disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 06-30-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

HCPCS code E0217 (water circulating heat pad) date of service 01-24-05 denied with denial code "893" (this code is invalid, not covered code or has been deleted from the Texas Fee Schedule. Per the 2005 DMEPOS Fee Schedule HCPCS code E0217 is valid. Reimbursement is recommended in the amount of **\$496.47**.

HCPCS code E1399 (elastic support belt) date of service 01-24-05 denied with denial code "426" (reimbursed to fair and reasonable). The carrier made a payment of \$49.95. Per Rule 134.202(c)(6) no additional reimbursement is recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 2005 DMEPOS Fee Schedule, Rule 134.202(c)(6)

**PART VII: DIVISION DECISION AND ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of \$541.47. The Division finds that the requestor was the not the prevailing party and is not entitled to a refund of the IRO fee. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Ordered by:

11-08-05

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date of Order

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

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

**NOTICE OF INDEPENDENT REVIEW**

**NAME OF PATIENT:** \_\_\_\_\_  
**IRO CASE NUMBER:** M5-05-2590-01  
**NAME OF REQUESTOR:** Lonestar DME  
**NAME OF PROVIDER:** Marivel Subia, D.C.  
**REVIEWED BY:** Board Certified in Chiropractics  
**IRO CERTIFICATION NO:** IRO 5288  
**DATE OF REPORT:** 08/12/05 (REVISED 08/24/05)

Dear Lonestar DME:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for Texas Workers' Compensation Commission (TWCC) to randomly assign cases to IROs, TWCC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Chiropractics and is currently listed on the TWCC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician 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 providers or any of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

### **REVIEWER REPORT**

#### **Information Provided for Review:**

A Designated Doctor Evaluation performed on 10/22/04 by Carl G. Simpson, M.D.  
A letter of medical necessity for durable medical equipment (DME) dated 01/14/05 from an unknown provider (the signature was illegible)  
A short page summary from Vista Hospital of Dallas dated 01/18/05 from C.M. Schade, M.D.  
An operative report dated 01/18/05 from Dr. Schade  
A prescription and certificate of medical necessity dated 01/25/05 for the purchase of an EMS unit from an unknown provider (the signature was illegible)  
An evaluation by Andrew Small, M.D. dated 01/25/05  
An evaluation with Steven Eaton, M.D., at D.F.W. Pain Consultants, dated 01/31/05  
Follow-up evaluations with Dr. Small on 02/03/05, 02/17/05, 03/01/05, and 03/15/05  
A letter of medical necessity dated 02/25/05 from Maribel Subia, D.C.  
Another letter of medical necessity for DME dated 03/15/05 from Dr. Subia  
An additional follow-up evaluation with Dr. Small dated 03/24/05  
An operative report from Dr. Eaton dated 04/08/05  
A letter of medical necessity dated 04/18/05 from Dr. Subia for a conductive garment  
A request for reconsideration addressed to Texas Mutual dated 04/19/05 from George Hanford, a representative of Lonestar DME  
A progress note from Dr. Eaton dated 04/28/05  
Another letter to the Texas Workers' Compensation Commission (TWCC) from Mr. Hanford dated 05/25/05  
An operative report dated 05/27/05 from Dr. Eaton  
A letter from Texas Mutual dated 07/07/05 regarding the carrier's statement with respect to the medical dispute from LaTreace Giles, R.N.

#### **Clinical History Summarized:**

On 10/22/04, Dr. Simpson performed a Designated Doctor Evaluation and placed the claimant at Maximum Medical Improvement (MMI) on 10/22/04 and assigned him a 5% whole person impairment rating. On 01/14/05, an unknown physician provided a letter of medical necessity for Biofreeze and a lumbar support belt. The claimant received a cervical epidural steroid injection (ESI) on 01/18/05 from Dr. Schade. On 01/24/05, an unknown provider gave the claimant a prescription for the purchase of an EMS unit. On 02/25/05, Dr. Subia recommended

an infrared heating system, a therapeutic lumbar support brace, and a therapeutic cervical collar with a thermal underlay. Dr. Subia provided a letter of medical necessity on 03/15/05 for a body ball and Theraband exercise ball. On 04/18/05, Dr. Subia prescribed a conductive garment for the lumbar and cervical areas, as well as a Theraball. On 04/19/05, Mr. Hanford addressed a letter to Texas Mutual regarding the denial for the DME. Dr. Eaton performed left L2, L3, L4, L5, and S1, median branch nerve blocks on 05/27/05. On 07/07/05, LaTrece Giles, R.N. provided a carrier statement with respect to the dispute. She noted the dispute issue was reimbursement for a cryo unit, a conductive garment, Biofreeze, a therapy ball, and additional reimbursement for an elastic support. Ms. Giles noted it was carrier's position that the disputed DME was not medically necessary, as it did not do what Dr. Subia stated it would, specifically decreasing pain and the use of medications.

**Disputed Services:**

A conductive garment and DME

**Decision:**

I agree with the insurance carrier in part as I do not feel that the conductive garment would be reasonable or necessary. However, I do feel that the therapy ball and Biofreeze would be reasonable and necessary.

**Rationale/Basis for Decision:**

The therapy ball, support belt, and Biofreeze would be considered medically reasonable and necessary as related to this injury. However, the cryotherapy unit and conductive garment would not be considered medically reasonable and necessary. The question remains as to whether those products satisfy the qualification of Section 408.021 (31 of the Texas Labor Code), which substantiates the need for care that cares or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. Based upon the supplied documentation, the purpose of the conductive undergarment and the cryotherapy unit was to decrease the claimant's pain level and allow him to be more functional, thereby decreasing the amount of pain medication as being prescribed to the claimant. Those plans were not substantiated by the documentation provided. In fact, it appeared the claimant's condition has continued to cause regular aggravations and he has had to have an increase in pain medication, as well as undergo pain management intervention. This was noted during the period of time he was using those products on a home basis to try to alleviate the symptoms. Therefore, there was a lack of documentation to substantiate the products actually worked for this claimant. Therefore, they would not qualify for support under Section 408.021 of the Texas Labor Code.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this 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 twenty (20) calendar days** of your receipt of this decision (28 Texas Administrative Code 148.3).

This decision is deemed received by you **five (5) calendar days** after it was mailed and the first working day after the date this decision was placed in the carrier representative's box (28 Texas Administrative Code 102.5 (d)). A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P. O. Box 17787  
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to TWCC via facsimile or U.S. Postal Service on 08/24/05 from the office of Professional Associates.

Sincerely,

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Lisa Christian  
Secretary/General Counsel