

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.: M5-05-2609-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Ace American Insurance Company 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		
02-22-05	02-22-05	E0217 and E0731	<input type="checkbox"/> Yes <input checked="" 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.

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 the Medical Review Division.

On 07-08-05, 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 E1399 (\$35.00) date of service 02-22-05 denied with "F" (procedure code submitted is not the proper code for this service. Please submit with the proper code). The DMEPOS code billed is a proper code, however, this is a DOP code and per rule 133.307(g)(3)(D), the requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The requestor has not provided sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. No reimbursement is recommended.

HCPCS code E1399 (\$15.00) date of service 02-22-05 denied with an explanation that reimbursement for procedure was withheld due to previous submission. This code is reviewed per Rule 134.202. This is a DOP code and per rule 133.307(g)(3)(D), the requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The requestor has not provided sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. No reimbursement is recommended.

Review of HCPCS code E1399 (\$15.00) date of service 02-22-05 revealed that neither party submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

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

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

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 en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 23, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker: _____
MDR Tracking #: M5-05-2609-01
IRO Certificate #: IRO 5263

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed 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 Chiropractic reviewer who has an ADL certification. The reviewer 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- None supplied

Submitted by Respondent:

- Table of disputed services
- Peer review
- Chronological list of submitted records

- Letters of medical necessity
- Work status reports
- Concentra Medical Center notes
- Examination notes
- Daily notes
- FCE report
- E1
- Behavioral medicine consult report
- Designated doctor report
- MRI reports

Clinical History

According to the E1 dated ____, the claimant was driving a bus that hit an icy spot and went off the concrete and ran into the ditch. The claimant was seen at the emergency room in Emporia, Texas and had x-rays of his cervical spine, chest, and a CT of the skull, which were all negative for fracture. He reported to Marival C. Subia, D.C. for treatment and evaluation. Dr. Subia diagnosed the claimant with cervical disc disorder, lumbar disc disorder, complete rupture of the rotator cuff, and other unspecified injuries to the knee, leg, ankle and foot. Chiropractic therapy began. The claimant was referred to Andrew B. Small, III, M.D. for evaluation and treatment. Dr. Small prescribed medications. On 2/15/05 the claimant underwent a lumbar MRI which was negative for herniation, fracture or osseous lesion. The claimant underwent an MRI of the cervical spine which revealed subligamentous herniations at C4/5, C5/6, and C6/7 that did not efface the ventral subarachnoid space. An MRI of the brain was normal. An MRI of the right shoulder revealed degenerative hypertrophy of the acromioclavicular joint, which abuts the supraspinatus muscle in the neutral position.

The claimant was seen on 3/16/05 with Steven W. Eaton, M.D. who diagnosed the claimant with bilateral L5/S1 facet dysfunction and bilateral sacroiliitis. On 4/6/05 the claimant underwent a behavioral medicine consult. In April 2005 the claimant underwent an FCE that revealed he was at a light physical demand level, although his normal job duties were at a medium physical demand level. On 4/20/05 the claimant was seen by Jerry Michael McShane, D.C. for a designated doctor evaluation. Dr. McShane placed the claimant at MMI as of 4/20/05 with a 7% whole person impairment. The documentation ends here.

Requested Service(s)

DME (water circulating heat pad with pump, form fit conductive garment to deliver treatment) on 2/22/05

Decision

I agree the carrier that the services in dispute are not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, it appears that the claimant sustained a sprain/strain to his cervical region, lumbar region and right shoulder region as a result of the compensable injury dated _____. The claimant underwent medically necessary passive and active treatment protocols that were co-managed by multiple medical doctors which appear in line with current treatment protocols. The durable medical equipment in question was listed on a one page letter of medical necessity which did not support the need for the equipment which was prescribed. The documentation supplied for rationale of the use of a cervical conductive garment and lumbar conductive garment reported it was necessary to allow blood circulation to increase. This could be accomplished at home using over the counter heat packs or a typical heating pad. The prescribed units were not objectively supported by the documentation supplied and do not appear necessary in the treatment of the compensable injury dated _____.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 23rd day of August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder