

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 106 Desoto, Texas 75115	MDR Tracking No.: M5-05-2686-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance Box 28	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		
02-18-05	03-17-05	DME (water circulating hoist, form fitting conduct garment, cervical traction and DME not classified)	<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.

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

08-12-05

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

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.

August 10, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2686-01
TWCC #: _____
Injured Employee: _____
Requestor: Lonestar DME
Respondent: Liberty Mutual Insurance
MAXIMUS Case #: TW05-0147

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 27-year old male who sustained a work related on _____. The patient reported that while in the process of changing positions, he slipped on oil on the floor causing his feet to go out from under him, and landed directly on his low back and struck his head against the floor. He reported he did not lose consciousness. His diagnoses include cervicothoracic strain, cerebral concussion syndrome, lumbosacral strain/contusion, sacroiliac strain, post traumatic cephalgia, and adjustment disorder with mixed anxiety. His treatment has included medications, rehabilitation and behavioral health care. His treatment has also included durable medical equipment (DME) including water circulating hoist, form fitting conduct garment, cervical traction, and DME not classified from 2/18/05-3/17/05.

Requested Services

DME (water circulating hoist, form fitting conduct garment, cervical traction, and DME not classified) from 2/18/05-3/17/05.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter of Medical Necessity – 2/25/05, 5/4/05
2. Product Information for cryotherapy cold water therapy, Opti-ice therapy, TheraKnit, and Biofreeze.
3. Request for Appeal – 6/6/05
4. Biofeedback Therapy Notes - 5/5/05-6/8/05
5. Individual Psychotherapy Notes – 4/18/05-6/8/05
6. Clinical Notes S.O.A.P. Notes – 2/8/05-5/27/05
7. Chronic Pain Management Group Note – 3/1/05, 4/12/05, 5/10/05
8. Report of Medical Evaluation Report – 5/17/05
9. Psychotherapeutic Group Notes – 4/20/05, 4/27/05
10. NMES Muscle Stimulator Supply Order – 2/18/05
11. Psychophysiological Profile Assessment – 4/18/05
12. Medical Consultation and follow-ups (Andrew B. Small, III, MD) – 2/10/05, 2/17/05, 2/14/05,
13. Neurologic Consultation Report – 3/9/05
14. Records from Kathy Toler, MD – 12/6/04
15. Summit Rehab Centers Letter of Medical Necessity – 3/24/05
16. DME Prescription – 2/25/05
17. ERGOS Evaluation Summaries – 1/27/05, 2/18/05, 5/23/05
18. Behavioral Medicine Consultation Report – 2/4/05
19. DFW Pain Consultants Record – 1/19/05
20. Concentra Medical Centers Records – 10/28/04-11/2/04
21. Metroplex Specialties Record – 12/16/04
22. Kclinic Rehabilitation Centers Records – 11/3/04-12/17/04
23. WC Initial Evaluations (SJ Kechejian, MD) – 11/3/04, 11/5/04
24. Baylor Medical Center Records – 10/26/04

Documents Submitted by Respondent:

- I. None submitted.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted the patient was injured on ___ and received passive and active treatment for 4 months. The MAXIMUS chiropractor reviewer noted that since the patient was past 16 weeks from the date of injury, he was in the tertiary phase of treatment from 2/18/05-3/17/05 according to the National Spine Society's Clinical Guidelines for unremitting back pain. The MAXIMUS chiropractor reviewer explained that treatment in this phase of care includes chronic pain management, pharmacological interventions, behavioral techniques, ESIs, and functional restoration. The MAXIMUS chiropractor reviewer also noted that the treatments in question, including cervical traction unit, water circulating unit, and conductive garment are all treatments that are performed in the initial and secondary phases of care. The MAXIMUS chiropractor reviewer explained that since the patient had documented failure to respond to non-operative treatment prior to issuing of these DME products, and the patient had reached the tertiary phase of care, there is no evidence to indicate medical necessity of the water circulating hoist, form fitting conduct garment, cervical traction, and DME not classified. (Clinical Guidelines for Unremitting Back Pain, National Spine Society' 2002.)

Therefore, the MAXIMUS chiropractor consultant concluded that the DME (water circulating hoist, form fitting conduct garment, cervical traction, and DME not classified) from 2/18/05-3/17/05 were not medically necessary to treat the patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
Appeal Officer, State Appeals