

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 % George Hanford 1509 Falcon Drive Suite 106 Desoto, Texas 75115	MDR Tracking No.: M5-05-2778-01
	TWCC 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: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ISSUES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
4-4-05	4-4-05	HCPCS Codes E0745-RR, E0731-NU	<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.

On 7-19-05 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.

The carrier denied E0217-U as "893 – This code is invalid, not covered or has been deleted from the Texas Fee Schedule." However, this HCPCS code is valid according to the DMEPOS 2004 Fee Schedule. Recommend reimbursement of \$496.47.

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 a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the disputed services which were not denied for medical necessity consistent with the applicable fee guidelines totaling \$496.47 plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

	Donna Auby	8-12-05
Authorized Signature	Typed Name	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.

August 11, 2005

TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ____

EMPLOYEE: ____

POLICY: M5-05-2778-01

CLIENT TRACKING NUMBER: M5-05-2778-01

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:

RECORDS RECEIVED FROM THE STATE:

Notification of IRO Assignment dated 7/19/05, 7 pages

RECORDS RECEIVED FROM THE REQUESTOR:

Letter from MRIoA requesting records and fees dated 7/20/05, 1 page

Notification of IRO assignment and request for records/fees dated 7/19/05, 3 pages

Letter from Lonestar DME dated 7/19/05 Providers Request Cancel IRO, 3 pages

Medical Dispute Resolution Request, undated, 3 pages

Letter from Lonestar DME dated 6/14/05, 2 pages

EOB dated 4/4/05, 2 pages

Letter from Lonestar DME dated 5/17/05, 1 page

Letter of Medical Necessity dated 5/16/05, 1 page

Internet printout of Cryotherapy Cold Water Therapy & Muscle Stimulators device undated, 11 pages

EOB 4/4/05, 2 pages

HCFA billing 4/4/05, 2 pages

Durable Medical Equipment form from Physician Resource Group dated 3/31/05, 1 page

Lone Star Overnight delivery form, 1 page

RECORDS FROM RESPONDENT:

Letter to MRIoA dated 8/6/05, 2 pages

MRI report of Lumbar Spine, 11/30/04, 2 pages

TWCC 69 Report of Medical Evaluation, 1 page

Churchhill Evaluation Centers report of medical evaluation dated 2/22/05, 2 pages

Review of Medical History & Physical Exam 2/22/05, 5 pages

Letter of Medical Necessity dated 5/16/05, 1 page

Summary of Treatment/Case History:

The claimant reported a lumbar spine injury on ____ when he slipped in some mud.

Questions for Review:

DOS 4/4/05:

1. Were the neuromuscular stimulator and lumbar conductive garment medically necessary to treat this patient's injury?

Explanation of Findings:

1. Were the neuromuscular stimulator and lumbar conductive garment medically necessary to treat this patient's injury?

No. The Philadelphia Panel Physical Therapy Study reported that electrical muscle stimulation is a passive modality and the study does not lend evidence to ongoing benefit from this type of treatment after the initial six weeks. The National Coverage Determination Report from the Centers for Medicare and Medicaid reports that the two purposes for such a unit are for treatment of muscle atrophy or to enhance functional activity in neurologically impaired patients. In this case, there is nothing in the medical records to suggest that the patient had either a spinal cord injury or muscle atrophy. In fact, there were no treatment records submitted by the provider so there was no support whatsoever for the medical necessity of the equipment.

Conclusion/Decision to Not Certify:

The neuromuscular stimulator and lumbar conductive garment are not medically necessary to treat this patient's injury.

References Used in Support of Decision:

This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty-five years.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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