



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

PREVAILING PARTY DETERMINATION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestor's Name and Address:

Lonestar DME
 1509 Falcon Drive Suite 106
 Desoto TX 75115

MDR Tracking No.: M5-05-2813-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Zenith Insurance Company Box 47

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: 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 Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

Consistent with the requirements in Rule 133.308, the Division has reviewed the IRO decision and determined:

- The requestor is the prevailing party.
- The respondent is the prevailing party.

PART III: ADDITIONAL INSTRUCTIONS

The parties are instructed to review the IRO decision and take appropriate action. For any services that may have been found to be medically necessary, the insurance carrier is instructed to process those services through their bill review and payment processes, including issuing any additional amounts due consistent with the established fee guidelines. If the requestor was the prevailing party, the carrier must refund the amount of the IRO fee within to the requestor within 30 days of receipt of this order.

Issued by:

9-8-05

 Authorized Signature

 Typed Name

 Date

August 30, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2813-01
TWCC #: ____
Injured Employee: ____
Requestor: Lonestar DME
Respondent: Zenith Insurance
MAXIMUS Case #: TW05-0173

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 35-year old male who sustained a work related injury on _____. The patient reported that while working at a kitchen, he slipped on a piece of chicken with his left foot and falling. He also reported that he injured his left knee, ankle and lumbar spine in the fall. Diagnoses included displacement of lumbar intervertebral disc without myelopathy, mononeuritis of lower limb, tarsal tunnel syndrome, and derangement of medial meniscus. Treatment has included electrical stimulation, mechanical traction, manipulation, myofascial release and therapeutic exercise.

Requested Services

E0217 water circulating heat pad with pump, E0105 cane, quad or three prong, and E0731 form fitting conductive garment for delivery of TENS or NMES on 12/30/04

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

Documents Submitted by Requestor:

1. Letters of Medical Necessity – 1/18/04, 5/13/05
2. Clinical Notes Initial Examination – 11/18/04

Documents Submitted by Respondent:

1. Peer Review – 1/15/05

Decision

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

Rationale/Basis for Decision

MAXIMUS CHDR chiropractor consultant indicated the patient injured his low back, left ankle, and left knee on ____.

MAXIMUS CHDR chiropractor consultant noted that the purpose of the water circulating unit and conduction garment is to reduce cell drainage, reduce swelling, and reduce inflammation in the left knee and lumbosacral spine.

MAXIMUS CHDR chiropractor consultant explained that the only medical record for review was from an initial evaluation on 11/18/04. MAXIMUS CHDR chiropractor consultant also indicated that this evaluation was performed over a month prior to the issuing of the durable medical equipment on 12/30/04. MAXIMUS CHDR chiropractor consultant noted that there are no medical records or documentation from 12/30/04 that state that the patient had inflammation, swelling, or pain in the lumbar spine, left knee or left ankle. MAXIMUS CHDR chiropractor consultant indicated there also are no medical records or documentation that indicate the patient was having difficulty walking. MAXIMUS CHDR chiropractor consultant explained there are no medical records or documentation that support the medical necessity of the equipment provided to the patient on 12/30/04.

Therefore, the MAXIMUS physician consultant concluded that the E0217 water circulating heat pad with pump, E0105 cane, quad or three prong, and E0731 form fitting conductive garment for delivery of TENS or NMES on 12/30/04 were not medically necessary for treatment of this patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department