



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

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-05-2979-01
Lonestar DME % George Hanford 1509 Falcon Drive Suite 106 Desoto, Texas 75115	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary from Table of Disputed Services states, "Supplied additional documentation via Rule 133.304. Carrier never responded. Several messages left. Carrier never returned calls."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form. Position summary from Table of Disputed Services states, "Response to Request for Reconsideration was sent to provider on 5-28-05. The record shows our telephone call received on 6-22-05 and returned on 6-23-05."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-3-04	E1399-NU and L0500-NU	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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 disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

PART VII: DIVISION DECISION

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 not entitled to additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

11-07-05

Authorized Signature

Typed Name

Date of Findings and Decision

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.

October 28, 2005

TDI, Division of Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-2979-01
TWCC#: _____
Injured Employee: _____
DOI: _____
SS#: _____
IRO Certificate No.: IRO 5055

Dear ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the DWC Approved Doctor List.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,

Gilbert Prud'homme
General Counsel
GP:dd

REVIEWER'S REPORT M5-05-2979-01

Information Provided for Review:

DWC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Medical Necessity Letter

Information provided by Respondent:

Treating MD

Clinical History:

The claimant was employed by _____ when she was involved in a work related injury on _____. The claimant was involved in a trip and fall event. Claimant was diagnosed with lumbosacral radiculitis and acquired spondylolisthesis. As of 06/15/05, the claimant has been out of work for approximately 2 ½ years. Arthroscopy was performed over the right/left knee by John McConnell MD, including bilateral medial meniscectomies on 07/14/03. Designated Doctor examination was performed by Dr. Alan Berg on 01/23/04, Maximum Medical Improvement (MMI) and a 17% whole person impairment of function was assigned.

Disputed Services:

Carrier is in denial of provider's utilization of E1399-NU and L0500-NU.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion the services in dispute as stated above were not medically necessary in this case.

Rationale:

Claimant had bilateral arthroscopic meniscectomies performed on 07/14/03, by John McConnell MD. MMI and a 17% impairment of function were assigned in a designated doctor evaluation that was performed on 01/23/04. Durable Medical Equipment (DME) provider implemented charges for a flexipac hot/cold compress and a lumbar support on 12/03/04.

No qualitative/quantitative data exists to establish clinical efficacy necessary to support the implementation of the provider's services that include implementation of flexipac hot/cold compress and a lumbar support.

Screening Criteria/Treatment Guidelines/Publications Utilized:

The aforementioned information has been taken from the following guidelines of clinical practice and/or peer-reviewed references.

- Overview of implementation of outcome assessment case management in the clinical practice. Washington State Chiropractic Association; 2001. 54p.
- St-Pierre DM. Rehabilitation following arthroscopic meniscectomy. Sports Med. 1995 Nov;20(5):338-47.
- Umar M. Ambulatory arthroscopic knee surgery results of partial meniscectomy. J Pak Med Assoc. 1997 Aug;47(8):210-3.