



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

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.: M5-06-0023-01

Claim No.:

Injured Worker's Name:

Respondent's Name and Address:

Texas Mutual Insurance Box 54

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
3-23-05 to 6-6-05	E0217, E0745-RR, E0731 and E0235	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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, 134.202

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

Findings and Decision by:

Medical Dispute Officer

12-16-05

Authorized Signature

Typed Name

Date

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.

P-IRO

An Independent Review Organization
7626 Parkview Circle
Austin, Texas 78731
Phone: 512-346-5040
Fax: 512-692-2924

December 8, 2005

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee _____
TDI-DWC # _____
MDR Tracking #: M5-06-0023-01
IRO #: 5312

P-IRO, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to P-IRO for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

P-IRO has performed an independent review of the proposed care 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL). The P-IRO Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including: explanation of reviews, notes from Concentra Medical Centers, MRI of Right Wrist 4/22/2003, operative report from North Texas Surgery Center 7/29/2003, MR Scan of Right Wrist 6/18/2004, operative report from Baylor Medical Center of Garland, notes from Jeff Rodriguez DC, CT Right Wrist, Physical Therapy notes, RME from Harold Nachimson MD, FCE dated 1/28/2004, mental health evaluation from Robert Freedenfeld PhD., notes from Locum Holtzman MD, notes from Hand and Upper Extremity Centers, notes from L.T. Johnson MD, Bone Scan Right Wrist, upper extremity NCV/EMG, X-Ray Right Wrist, Impairment Rating 9/3/2003.

CLINICAL HISTORY

There is limited history provided. On ____ The Patient was injured while using an air gun repetitively at work. The Patient stated she noticed swelling and felt pain in her right wrist, which radiated up her right arm.

DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of water circulating heating pad – E0217, neuromuscular stimulator – E0745-RR, conductive garment – E0731 and paraffin bath unit – E0235 for dates of service 3/23/2005 through 6/6/2005.

DETERMINATION / DECISION

The Reviewer agrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

None of the disputed services are considered reasonable and medically necessary as outlined by the *Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters*. At this point in treatment (8 weeks post-surgery), The Patient should be instructed to perform isometric stretches and strengthening, with the emphasis on progressing The Patient into a work conditioning/work hardening program. Passive modalities would no longer be medically necessary unless used on a random basis to help with isolated inflammation. Therefore, the use of passive modalities 8 weeks post injury for 9 weeks is unreasonable and medically unnecessary.

Screening Criteria

1. Specific:

Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

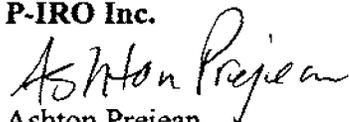
P-IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. P-IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of P-IRO Inc., I certify that there is no known conflict between the Reviewer, P-IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

P-IRO is forwarding by facsimile, a copy of this finding to the DWC.

Sincerely,

P-IRO Inc.



Ashton Prejean

President & Chief Resolutions Officer

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.

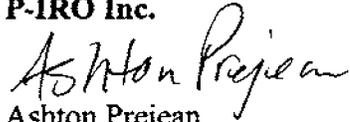
The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to DWC via facsimile on this 8th day of December 2005.

Name and Signature of P-IRO Representative:

Sincerely,

P-IRO Inc.

A handwritten signature in cursive script that reads "Ashton Prejean".

Ashton Prejean

President & Chief Resolutions Officer