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.: M5-06-0113-01
Lonestar DME 1509 Falcon Drive Suite 106 Desoto, Texas 75115	Claim No.: Injured Employee's Name:
Respondent's Name and Address: St. Paul Fire and Marine Insurance, Box 05	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 states, "I request that your office aid in the dispute process by assigning an IRO to address the medical necessity issue and that Lonestar DME is entitled to payment under Labor Code 408.021."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form. Position summary states, "The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. The documentation provided does not establish medical necessity."

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)
5-3-05, 6-3-05, 6-8-05	E045-RR, E0217-NU, E0731, A4556 and A4595	☐ Yes ☒ 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:

		10-19-05
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 17, 2005

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M5-06-0113-01
CLIENT TRACKING NUMBER: M5-06-0113-01/5278

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 – 2 pages
Medical Dispute Resolution Request/Response – 3 pages
Table of Disputed Charges – 1 page
Explanation of Review – 3 pages

Records Received from Respondent:
Letter from S. Rhett Robinson to MRIoA– 2 pages
Letter from S. Rhett Robinson to Amy Rich – 2 pages
Letter from Gary Martin, DC to St. Paul Fire and Marine – 2 pages
Explanations of Review – 32 pages

Records Received from the Requestor:
Letter from George Hanford, Representative for Lonestar DME to TWCC – 2 pages
Letters from George Hanford, Representative for Lonestar DME to St. Paul Travelers – 4 pages
Explanations of Review – 5 pages
Letters of Medical Necessity – 4 pages
HCFAs – 6 pages
Prescription – 3 pages

Summary of Treatment/Case History:
The patient is a diabetic male of unknown age, who, on ___, was lifting blocks while twisting and felt pain in his lower back. He continued working despite the pain, but eventually reported the incident to his employer. He was seen initially by the "company doctor," who diagnosed L5-S1 radiculopathy, and then presented himself to a doctor of chiropractic who assumed his care.

Questions for Review:
Item(s) in Dispute: #E0745-RR (neuromuscular stimulator electrodes), #E0217-NU (water circulating heat pad), #E0731 (form-fitting conductive garment), #A4556 (electrodes per pair) and #A4595 (electrical stimulator supplies).

Explanation of Findings:
Item(s) in Dispute: #E0745-RR (neuromuscular stimulator electrodes), #E0217-nu (water circulating heat pad), #E0731 (form-fitting conductive garment), #A4556 (electrodes per pair) and #A4595 (electrical stimulator supplies).

No. In this review, no actual treatment records were available for review. Therefore, it is unknown what types of various other therapies and/or treatments were attempted – in addition to the durable medical equipment in dispute – and, whether or not they were efficacious or beneficial. In addition, since no treating doctor records were available, the actual objective and

subjective patient response to this equipment was not documented. As such, without medical treatment records to address these issues, there is less than sufficient documentation to support the medical necessity of the disputed treatment.

Conclusion/Decision to Not Certify:
The #E0745-RR (neuromuscular stimulator electrodes), #E0217-NU (water circulating heating pads), #E0731 (form-fitting conductive garment), #A4556 (electrodes per pair), and #A4595 (electrical stimulator supplies) dispensed on 5/3/05, 6/3/05 and 6/8/05 were 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 given numerous presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty 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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