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.: M5-06-0149-01
Lonestar DME % George Hanford 1509 Falcon Drive Suite 106 Desoto, Texas 75115	Claim No.: Injured Employee's Name:
Respondent's Name and Address: TX Mutual Insurance Company, Box 54	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary asks that the Division "assign an IRO to address the medical necessity issue… and enter a Decision and Finding citing that Texas Mutual did not properly comply with Rule 133.304, Rule 134.201, Rule 133.300 and the Labor Code and that Lonestar DME is entitled to payment."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. No position summary was received.

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)
5-5-05	Ice Pack, Bed Wedge, and Conductive Garment	☐ 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:

		11-10-05
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 25, 2005

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

Re: Medical Dispute Resolution
MDR #: M5-06-0149-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ___:

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 certified in Internal Medicine, 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
M5-06-0149-01

Information Provided for Review:
DWC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
    Correspondence
Information provided by Respondent
Information provided by Treating MD:
    Office Visit 09/20/05
    Nerve Conduction Study 06/07/05
Spine:
    Office Visit 07/21/05
Pain Management:
    Office Notes 08/08/05 – 09/26/05
    OR Report 08/23/05 – 09/16/05
    Radiology Reports 04/20/05 – 08/23/05

Clinical History:
This is the history of a 33-year-old gentleman who injured himself on ___ while lifting a 400-pound marble counter. The patient apparently injured his right ankle and back. He continues to have chronic pain status post the injury.

Disputed Services:
The disputed services are an ice pack, bed wedge and conductive garment.

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:
The basis for my agreement is that after review of the patient's medical records, the ones that were provided, there is no documentation stating that these 3 items were advised by the medical doctors that the patient is seeing. Numerous reports were reviewed revealing the patient did have signs of lumbar radiculopathy, possibly a chronic right ankle sprain. The recommendations made were epidural steroid injections, of which apparently the patient did have three as per the operative reports as well as the notes from his doctors, as well as for the physical therapy and the use of nonsteroidals anti-inflammatory drugs, namely Naprosyn, and analgesic Ultram. I cannot dispute that these items may have helped, but there is no documentation stating that they were really recommended by the patient's treating physicians.