



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: Lonestar DME 1509 Falcon Drive Suite 106 Desoto, Texas 75115	MDR Tracking No.: M5-06-0152-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Fidelity & Casualty Company Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC package

POSITION SUMMARY: Per the table of disputed services "Carrier denied all dates of service listed as un nec treatment, "request for reconsideration" was done for all dates. Carrier respond to some adversely and others never respond at all".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC package submitted by Requestor

POSITION SUMMARY: Per the table of disputed services "Denied as unnecessary medical".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
02-24-05 to 04-22-05	E0731, E0745-RR, A4556 and A4595	<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

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:

12-09-05

Authorized Signature

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 12/7/05

TDI-DWC Case Number:	
MDR Tracking Number:	M5-06-0152-01
Name of Patient:	_____
Name of URA/Payer:	Lonestar DME
Name of Provider: (ER, Hospital, or Other Facility)	Lonestar DME
Name of Physician: (Treating or Requesting)	Richard Marks, MD

November 22, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

CLINICAL HISTORY

Records reviewed included:

- * Liberty Mutual records to include Richard A. Marks, MD; Up & Open Imaging; Richardson Medical Center; Physician Resource Group; Lonestar DME; Professional Reviews, Inc.; Vista Rehabilitation; Butler-Shahan Physical Therapy; and
- * Lonestar DME records in addition to Concentra; Helmsman Management Services; Physician Resource Group; Richardson Orthopaedic Surgery and Sports Medicine; Richard A. Marks, MD.

49-year-old female with history of work related OTJI on ____, while repetitively lifting a 15# mold. Symptoms worsening with time, had recent MRI on 7-22-04 that was read as broad based disc protrusion L-4/5 with moderate to severe disc dehydration at that same level. A 3 level discogram was approved on 11-8-2004, and revealed normal findings at L-3/4 and L-5/S-1 but with posterior fissuring and concordant pain at L-4/5.

REQUESTED SERVICE(S)

Form fitting conductive garment; neuromuscular stimulator; electrodes per pair; and electrical stimulator.

DECISION

Uphold carrier's prior denial.

RATIONALE/BASIS FOR DECISION

While the treatment of chronic degenerative spine disease could include treatment with a Neuromuscular Stimulator, this case is limited to treatments that are the direct result or repetitive lifting of a 15# mold in _____. The diagnostics reveal IDD at L-4/5 with a positive discogram on 11-8-2004, 13 years after the OTJI- this is a new process and not relatable within reasonable medical probability to repetitive lifting injury in _____. While the proposed treatment may be a reasonable treatment for an L-4/5 IDD pain syndrome, it is not likely related to the OTJI of _____.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider 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 IRO.

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

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

In accordance with Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 23rd day of November, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell