

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Nestor Martinez, D. C. & Pain & Recovery Clinic-North 6660 Airline Drive Houston, TX 77076	MDR Tracking No.: M5-05-1820-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
3-1-04	7-14-04	97032, 97140, 97112, 99212, 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

In accordance with Rule 133.308 (e)(1) dates of service 2-18-04 through 2-26-04 were untimely filed and will not be a part of this review.

Dates of service 6-25-04 through 6-30-04 with withdrawn by the requestor and will not be a part of this review.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review 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:

Donna D. Auby

6-15-05

Authorized Signature

Typed Name

Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)
Certificate # 5301

June 9, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-1820-01
RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 3.28.05.
- Faxed request for provider records made on 3.28.05.
- TWCC Order for payment from requestor issued 5.2.05.
- The case was assigned to a reviewer on 5.26.05.
- The reviewer rendered a determination on 6.7.05.
- The Notice of Determination was sent on 6.9.05.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of denied services: 99212 (office visit), 97032 (E-stem), 97140 (manual therapy tech), 97112 (neuromuscular re-education), 97110 (therapeutic exercises; DOS 3.1.04-7.14.04

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **uphold the denial**.

Summary of Clinical History

Mr. ____ sustained a work related injury ____, while employed with _____.

Clinical Rationale

The Lumbar MRI performed in March 2004 reflected a 2mm bulge L3-4, a 3mm disc herniation with neuroforaminal stenosis and nerve displacement. The patient, according to a review of physical therapy records, demonstrated no improvement, which would tend to suggest that the patient did not respond to the treatment. Positive response to treatment is a criteria for continuing any treatment. Continuing physical therapy treatment is contraindicated as unnecessarily expensive and, in this case, delayed the lumbar transforaminal selective epidural blocks that ultimately proved to be effective and relieving 80% of the patient's pain.

One on One therapeutic procedures beyond the acute phase of injury have been considered ineffective according to current Medicare guidelines, the Spine section of the American Academy of Orthopedic Surgeons, and North American Spine Society. There is no documentation provided, including the therapy notes, that the patient benefited from any of the therapeutic modalities provided, specifically, the services from 3.1.04-7.14.04. Therefore, these services are not deemed as medically necessary.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 15 years of patient care and orthopedic surgery.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is a diplomate of the *American Board of Orthopedic Surgery*, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 9th day of June, 2005. The TWCC Medical Dispute Resolution department will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.