MEDICAL DISPUTE RESOLUTION AMENDED FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor Pain & Recovery Clinic –North & Nestor Martinez, DC c/o Gilbert & Maxwell, P.L.L.C. P.O. Box 1984 Houston, TX 77251	MDR Tracking No.: M5-05-2703-01 **(Previously M5-04-2392-01)** TWCC No.: Injured Employee's Name:
Respondent's Lumbermens Mutual Casualty Co. Rep. Box #42	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF FEE DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	**To**			
4-21-03	**7-30-03**	**99213(44)**	**$48.00 X 44 dates**	**$0.00**
8-1-03	**10-17-03**	**99212(15)**	**$45.41 X 15 dates**	**$0.00**
5-5-03	**5-5-03**	**97110**	**$70.00**	**$0.00**
5-7-03	**6-9-03**	**97110(14)**	**$105.00 X 14 dates**	**$0.00**
5-5-03	**6-9-03**	**97250(15)**	**$43.00 X 15 dates**	**$0.00**
5-5-03	**6-9-03**	**97265(15)**	**$43.00 X 15 dates**	**$0.00**
5-5-03	**6-9-03**	**97112(15)**	**$35.00 X 15 dates**	**$0.00**
TOTAL DUE				**$0.00**

This AMENDED FINDINGS AND DECISION supersedes M5-04-2392-01 rendered in this Medical Payment Dispute involving the above requestor and respondent.

The Medical Review Division's Decision of 5-6-05 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 6-14-05. An Order was rendered in favor of the Requestor. The respondent disagreed with the MDR and appealed the decision.

The audit summaries indicate that the disputed services were paid. The respondent confirmed that payment was made for the following:

Office visits coded 99213 were paid for the following dates: 4-21-03, 4-23-03, 4-25-03, 4-29-03, 5-1-03, 5-2-03, 5-5-03, 5-7-03, 5-8-03, 5-13-03, 5-15-03, 5-16-03, 5-19-03, 5-22-03, 5-23-03, 5-27-03, 5-29-03, 5-31-03, 6-2-03, 6-5-03, 6-7-03, 6-9-03, 6-11-03, 6-13-03, 6-16-03, 6-18-03, 6-21-03, 6-23-03, 6-25-03, 6-27-03, 6-30-03, 7-2-03, 7-3-03, 7-7-03, 7-9-03, 7-11-03, 7-14-03, 7-16-03, 7-19-03, 7-21-03, 7-23-03, 7-25-03, 7-28-03, and 7-30-03.

Office visits coded 99212 were paid for the following dates: 8-1-03, 8-4-03, 8-6-03, 8-9-03, 8-11-03, 8-13-03, 8-15-03, 10-1-03, 10-4-03, 10-6-03, 10-8-03, 10-10-03, 10-13-03, 10-15-03, and 10-17-03.

Therapeutic procedures 97110 were paid for the following dates: 5-5-03, 5-7-03, 5-8-03, 5-13-03, 5-15-03, 5-16-03, 5-19-03, 5-22-03, 5-23-03, 6-9-03, 6-11-03, 6-13-03, 6-16-03, 6-18-03, and 6-21-03.

Myofascial release 97250 were paid for the following dates: 5-5-03, 5-7-03, 5-8-03, 5-13-03, 5-15-03, 5-16-03, 5-19-03, 5-22-03, 5-23-03, 6-9-03, 6-11-03, 6-13-03, 6-16-03, 6-18-03, and 6-21-03.

Joint mobilization 97265 were paid for the following dates: 5-5-03, 5-7-03, 5-8-03, 5-13-03, 5-15-03, 5-16-03, 5-19-03, 5-22-03, 5-23-03, 6-9-03, 6-11-03, 6-13-03, 6-16-03, 6-18-03, and 6-21-03.

Therapeutic procedures 97112 were paid for the following dates: 5-5-03, 5-7-03, 5-8-03, 5-13-03, 5-15-03, 5-16-03, 5-19-03, 5-22-03, 5-23-03, 6-9-03, 6-11-03, 6-13-03, 6-16-03, 6-18-03, and 6-21-03.

PART III: MEDICAL NECESSITY DISPUTE

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 4-1-04.

The IRO reviewed therapeutic exercises, myofascial release, joint mobilization, neuromuscular re-education, and manual therapy technique rendered from 4-21-03 through 10-17-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

PART IV: COMMISSION AMENDED DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Decision by:

Authorized Signature	Typed Name	Date of Order
		July 6, 2005

PART V: 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 AMENDED Decision should be attached to the request.

The party appealing the Division's AMENDED 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.

PART VI: INSURANCE CARRIER DELIVERY CERTIFICATION

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

Signature of Insurance Carrier: _____ Date: _____

Specialty Independent Review Organization, Inc.

May 19, 2005

TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-04-2392-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Chiropractor. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ received extensive physical medicine treatments after fracturing and lacerating his right hand and arm while at work on ___.

DISPUTED SERVICES

The items in dispute are: Therapeutic Exercise, Myofascial Release, Joint Mobilization, Neuromuscular Re-education, Manual Therapy Technique

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The treatment records that were submitted for this review indicate that the patient failed to respond to care. On most treatment dates, the patient's status remained the "same" and on all treatment dates, the patient continued to have difficulty pushing, pulling, reaching, lifting, carrying, climbing, sleeping and grasping. Therefore, according to the doctor's notes, there was a complete lack of

improvement. The treatment did not relieve or cure the effects of the injury, did not promote recovery and did not enhance the patient's ability to return to or retain employment; therefore, it did not meet the requirements of TX Labor Code 408-021.

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

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

Specialty IRO is forwarding this finding by US Postal Service to the TWCC.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director