



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: San Benito Medical Associates 351 N. Sam Houston San Benito, Texas 78586	MDR Tracking No.: M5-05-3264-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: ZNAT Insurance Company Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60 package, CMS 1500s, explanations of benefits and medical documentation
 POSITION SUMMARY: "According to the TWCC Guides regarding medical necessity the patient is entitled to all treatment provided to cure or relieve the effects of the injury to enable patient to return to work. The therapy treatment that was provided did improve his condition and enabled him to work light duty. Therefore I am requesting that you please consider the attached dates of services".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60
 POSITION SUMMARY: Zenith continues to believe that the disputed services were not medically necessary.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-16-04 to 09-22-04	97012, 97002, 95831, 95851, 97110, 97530	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,075.76
08-16-04 to 09-22-04	A4556, G0283, 97124 and 97035	<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 **prevailed** on the **majority** of disputed medical necessity issues.

Per Rule 133.308(e)(1) dates of service 08-09-04, 08-10-04 and 08-11-04 were not timely filed and are not eligible for review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(c)(1)

PART VII: DIVISION DECISION AND ORDER

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 entitled to additional reimbursement in the amount of \$1,075.76. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$650.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Ordered by:

10-20-05

Authorized Signature

Date of Order

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

TDI-WC Case Number:	
MDR Tracking Number:	M5-05-3264-01
Name of Patient:	
Name of URA/Payer:	San Benito Medical Associates
Name of Provider: (ER, Hospital, or Other Facility)	San Benito Medical Associates
Name of Physician: (Treating or Requesting)	Frank Torres, MD

October 17, 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:

- Milton E. Kirkwood, DO review;
- Mark S. Sanders, MD, RME;
- Brett A. Tice, PT, FCE; and
- MRI lumbar spine dated 7/6/04.

21-year-old male with onset of low back pain while at work on _____. He has lumbago and multi-level lumbar degenerative disk disease.

REQUESTED SERVICE(S)

Medical necessity of electrodes (A4556), mechanical traction (97012), electrical stimulation (G0283), massage (97124), ultrasound (97035), physical therapy re-evaluation (97002), muscle testing (95831), range of motion testing (95851), therapeutic exercises (97110), therapeutic+A13 activities (97530) for dates of service 8/16/04 through 9/22/04.

DECISION

Approve mechanical traction (97012), physical therapy re-evaluation (97002), muscle testing (95831), range of motion testing (95851), therapeutic exercise (97110) and therapeutic+A13 activities (97530).

Deny all other services.

RATIONALE/BASIS FOR DECISION

According to the Agency for Health Care Policy and Research (AHCPR) Guidelines, the North American Spine Society (NASS) treatment algorithms and Dr. Braddom's text *Physical Medicine and Rehabilitation*, the aforesated therapies are appropriate for this patient. On the other hand, therapeutic modalities are adjunctive treatments rather than primary curative interventions. Lastly, ongoing therapies, especially passive treatments in this setting i.e. chronic pain, are not supported in the peer review literature.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that all of the above statements are, to the best of my knowledge and belief, true and correct to the extent they are applicable to this case and my relationships. I understand that a false certification is subject to penalty under applicable law.

1. I had no previous knowledge of this case prior to it being assigned to me for review.
2. I have no business or personal relationship with any of the physicians or other parties who have provided care or advice regarding this case.
3. I do not have admitting privileges or an ownership interest (of 5% or more or \$100,000 or above, whichever is less) in the health care facilities where care was provided or is recommended to be provided. I am not a member of the board or advisor to the board of directors or any of the officers at any of the facilities.
4. I do not have a contract with or an ownership interest (of 5% or more or \$100,000 or above, whichever is less) in the utilization review agent, the insurer, the health maintenance organization, other managed care entity, payer or any other party to this case. I am not a member of the board or advisor to the board of directors or an officer for any of the above referenced entities.
5. I have performed this review without bias for or against the utilization review agent, the insurer, health maintenance organization, other managed care entity, payer or any other party to this case.

I hereby further attest that I remain active in my health care practice and that I am currently licensed, registered, or certified, as applicable, and in good standing.