



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:
Nestor Martinez, D.C.
6660 Airline drive
Houston, Texas 77076

MDR Tracking No.: M5-06-0466-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
Insurance Company of the State of PA
Box 19

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package
POSITION SUMMARY: None submitted

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: "All EOBs were included in the Requestor's original request. Carrier will respond with additional information upon assignment to an IRO".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-18-04 to 03-24-05	99212, 97110, 97140, 97112, 97032, 97545-WC and 97546-WC	<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.

CPT code 99212 dates of service 01-04-05, 01-05-05, 01-11-05, 01-12-05 and 01-14-05 listed on the table of disputed services were paid by the Respondent with check number 46755351 and are therefore no longer in dispute.

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:

02-01-06

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 1/16/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0466-01
Name of Patient:	
Name of URA/Payer:	Nestor Martinez, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dean McMillan, MD

January 6, 2006

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

- A. Orthopedic Notes from Richard Larry, M.D.
- B. Designated Doctor evaluation of Walter Kane
- C. Radiology reports
- D. Progress notes from Dean McMillan, M.D.

- E. Electrodiagnostic assessments
- F. FCE report
- G. Procedure notes
- H. Chiropractic notes
- I. Work conditioning notes
- J. IRO determination

This is a gentleman who fell backward sustaining a lumbar strain. There is clear documentation of degenerative changes in the lumbar spine as well as multiple level neurologic findings related to these osteophytic findings. Multiple conservative treatments ensued with no significant change as measured by multiple FCE's.

REQUESTED SERVICE(S)

Office Visits 99212
Therapeutic Exercises 97110
Manual Therapy 97140
Neuro-muscular re-education 97112
Electrical stimulation 97032
Work Conditioning 97545-WC
Work Conditioning each addl. Hour 97546-WC

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

As noted by Dr. McMillan, the majority of the findings in the lumbar spine (congenital stenosis, prior laminectomy changes, disc degeneration, scoliosis) are not a function of the compensable event. The treatments rendered appear to be addressing the sequale of these findings. There was no objectification of a job to return to so the work conditioning was not indicated. Also, the treatment for the radiculitis would not include a work conditioning program when the cause was the osteophytes noted. After the care delivered, a home-based, self-directed exercise program emphasizing overall conditioning and fitness is warranted and thus the need for manual therapy is not objectified. There was no paralysis so no neuromuscular re-education is warranted. Lastly, the requestor is confusing the pre-authorization standard of clinical indication with the reasonable and necessary standard of care.

References:

Official Disability Guidelines
ACOEM
Knutson's Physical Medical and Rehabilitation

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.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell