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.: M5-06-0504-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Box 54	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 by Requestor

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-01-04 to 01-26-05	97110, 97140 and 97112	☐ Yes ☒ 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:

		01-19-06
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 Austin, Texas 78735
Phone: 512-288-3300 FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0504-01
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 17, 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. Table of disputed services
B. Carriers summary
C. Progress notes of Dean McMillan, M.D.
D. Physical therapy notes of Dipti Patel, D.C.
E. Work Hardening Assessment of Denise Turboff, M.Ed.
F. RME by John Obermiller, M.D.

G. Designated Doctor eval by Kyle Jones, M.D.
H. Lumbar CT and myelogram
I. FCE
J. Orthopedic assessment

This is a 30 year old lady who reportedly slipped and fell sustaining a lumbar injury. She was evaluated by Dr. McMillan and diagnosed with a lumbar radiculitis. MRI was negative except for some multi-level degenerative changes. Physical therapy was initiated. AN electrodiagnostic assessment was reported as positive for a S1 nerve root compromise (although there was no disc protrusion or nerve root lesion on MRI). Physical therapy under the aegis of Dipti Patel, D.C. continued for two months with no objectified improvement. At three months after the date of injury, Dr. McMillan noted increased pain complaints. By February 2005 Dr. McMillan notes that she had improved, and tolerated a home program "very well". A work hardening assessment was completed and the progress notes indicated that straight leg raising was positive at "10°". Dr. Shanti had completed the ESI. In April 2005 physical therapy retreated to passive therapies. There was a noted request for a pain management program. The RME noted that the injury was a myofascial strain and that maximum medical improvement had been reached. It was reported that a Designated Doctor noted that maximum medical improvement had been reached and another Designated Doctor declared that maximum medical improvement had not been reached. Dr. Esses assessed the claimant and felt that there was cause for the radiculopathy. In September 2005 Dr. Jones noted that maximum medical improvement had been reached. A lumbar myelogram and CT scan noted multiple level disc bulges at L1 – L5.

REQUESTED SERVICE(S)
Therapeutic exercises (97110); Manual therapy technique(97140); and Neuro-muscular re-education (97112) from 11/1/04 – 1/26/05.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
The progress notes clearly noted that after three months of modalities and manual therapies that there was no improvement, and the complaints of pain were as high as initially reported. The standard of care is if a certain protocol is ineffective then alterations are to be made. The physical therapy reflects that the same treatments were completed with no alteration. The exception came after several months when physical therapy was reduced to passive modalities. The objective assessments (Plain films, MRI, CT & myelogram) all were indicative of minor degenerative changes only. In that this was a slip and fall, the injury at most would be a strain type complex. The literature is rife with papers that note that this type of problem resolved within three to six weeks by doing nothing. As noted by Wheeler and Stubbart, low back pain of more than 12 weeks duration is a "red Flag" and the specific barriers to recovery should have been identified and addressed. Noting the date of injury and the dates of service requested, continuation of such care for the many months noted was not clinically indicated or reasonable and necessary care.

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