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

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, TX 77076	MDR Tracking No.: M5-06-0507-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: TX Mutual Insurance Company, Box 54	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC-60 package. Position Summary states, "Attached are two copies of the DWC-60 and documentation."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC-60 form and Explanations of Benefits. Position Summary states, "Texas Mutual requests that the request for dispute resolution filed by NM Health Services be conducted under the provisions of the APA set out above."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
3-16-05 – 3-29-05	CPT code 99212 ($49.41 X 2 DOS)	☒ Yes ☐ No	$98.82
3-16-05 – 3-29-05	CPT code 97110 ($35.86 X 14 units)	☒ Yes ☐ No	$502.04
3-16-05 – 3-29-05	CPT code 97140 ($33.94 X 14 units)	☒ Yes ☐ No	$475.16
3-16-05 – 3-29-05	CPT code 97112 ($37.78 X 7 DOS)	☒ Yes ☐ No	$264.46
3-30-05 – 6-2-05	CPT codes 99212, 97110, 97140 97112	☐ Yes ☒ No	0

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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is $1,340.48.

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 entitled to additional reimbursement for the services involved in this dispute in the amount of $1,340.48 and is not entitled to a refund of the paid IRO fee. 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.

Findings and Decision by:

	Donna Auby	1-5-06
Authorized Signature	Typed Name	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.

January 3, 2006

Texas Department of Insurance Division of Texas Worker's Compensation
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-06-0507-01
DWC #:
Injured Employee: ___
Requestor: Nestor Martinez, DC
Respondent: Texas Mutual
MAXIMUS Case #: TW05-0242

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308 that allows for a dispute resolution by an IRO.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician who is board certified in physical medicine and rehabilitation on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that 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, was signed. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 55-year old male who sustained a work related injury on ___. The patient reported that while working as a machine operator he sustained a low back injury while lifting a toolbox. Evaluation and treatment have included diagnostic studies (MRIs, nerve conduction studies, myelogram), lumbar laminectomy, decompression and neurolysis procedure, physical rehabilitation, EMS, psychotherapy, medication and a chronic pain management program. Diagnoses have included radiculopathy, herniated disc and compression stenosis.

Requested Services

Manual therapy technique – 97140, neuromuscular re-education – 97112, therapeutic exercises – 97110 and office visits – 99212 from 3/16/05 to 6/2/05.

<u>Documents and/or information used by the reviewer to reach a decision:</u>

Documents Submitted by Requestor:

1. 1. None submitted

Documents Submitted by Respondent:

1. Carrier's Statement – 12/27/05
2. Record from Merrimon W. Baker, MD – 10/11/04
3. North Free Way Imaging Report – 10/14/04
4. Ultra Diagnostic Inc. Records – 10/15/04
5. Operative Reports – 11/5/04, 12/17/04
6. Pain & Recovery Clinic Notes – 11/22/04-7/7/05
7. Letter & Records from Stephen I. Esses, MD – 12/9/04, 4/7/05, 4/18/05
8. North Houston Imaging Center Notes – 3/4/05
9. Churchill Evaluation Center Report of Medical Evaluation – 3/23/05
10. Review of Medical History and Physical Examination – 3/23/05

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

Standard of Review

This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this 55-year old male sustained a work related injury on ___ and was subsequently diagnosed with left L5-S1 disc herniation. The MAXIMUS physician reviewer indicated he underwent left lumbar laminectomy at L4-5 on 11/5/04 and started physical therapy on 11/24/04. The MAXIMUS physician reviewer also noted he required irrigation and debridement due to an infection on 12/17/04 and continued with physical therapy. The MAXIMUS physician reviewer explained that physical therapy treatments consisted of joint mobilization, neuromuscular re-education, therapeutic exercise and treadmill along with passive modalities (e.g., heat, EMS, and myofascial release). The MAXIMUS physician reviewer indicated that re-evaluation on 2/7/05 indicated minimal improvement with range of motion and no changes in his pain level. The MAXIMUS physician reviewer noted the next evaluation on 3/29/05 indicated no significant improvement in range of motion, strength or pain level. The MAXIMUS physician reviewer noted that the physical therapy plan was to change treatment, but it does not clarify what change was recommended.

The MAXIMUS physician reviewer indicated the patient had a repeat lumbar CT myelogram that demonstrated persistent problems that may require surgical intervention. The MAXIMUS physician reviewer also noted that Dr. McMillan's office notes from 1/6/05 and 3/10/05 do not indicate any significant improvement in the patient's condition. The MAXIMUS physician reviewer noted there was no medical necessity for continued physical therapy treatment beyond 3/29/05 as there was no improvement in the patient's condition.

Therefore, the MAXIMUS physician reviewer concluded that the manual therapy technique – 97140, neuromuscular re-education – 97112, therapeutic exercises – 97110 and office visits – 99212 from 3/16/05 to 3/29/05 were medically necessary to treat this patient's condition. The MAXIMUS physician reviewer also concluded that manual therapy technique – 97140, neuromuscular re-education – 97112, therapeutic exercises – 97110 and office visits – 99212 from 3/30/05 to 6/2/05 were not medically necessary to treat this patient's condition.

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.

Sincerely,
MAXIMUS
Lisa Gebbie, MS, RN
State Appeals Department