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 and Fee 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.: M5-06-0512-01 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

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: "Texas Mutual requests that the request for dispute resolution filed by NM Health Services-North PA, be conducted under the provisions of the APA set out above.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
02-01-05 to 06-03-05	97140, 99212, 97032, 97110 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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 12-02-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99212 date of service 02-01-05 denied with denial code "790" (this charge was reduced in accordance to the Texas Medical Fee Guideline). A payment of $45.26 was made by the carrier. Additional reimbursement is recommended in the amount of **$4.15.**

CPT code 97140 dates of service 02-01-05 (2 units), 02-02-05 (2 units) and 02-04-05 (2 units) denied with denial code "790" (this charge was reduced in accordance to the Texas Medical Fee Guideline). Payments of $190.74 were made by the carrier.
Additional reimbursement is recommended in the amount of **$12.90.**

CPT code 97032 dates of service 02-01-05 and 02-02-05 denied with denial code "790" (this charge was reduced in accordance to the Texas Medical Fee Guideline). Payments in the amount of $38.00 were made by the carrier. Additional reimbursement is recommended in the amount of **$2.68.**

Review of CPT code 97032 date of service 02-04-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended in the amount of **$20.34.**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.307(e)(2)(B) and 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 $40.07. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the 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.

Ordered by:

		0 2-08-06
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.

CompPartners Final Report

URAC ACCREDITED EXTERNAL REVIEW

CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: ___
Texas IRO # : ___
MDR #: M5-06-0512-01
Social Security #: ___
Treating Provider: Dean McMillan, MD
Review: Chart
State: TX
Date Completed: 1/12/06
Date Amended: 1/31/06

Review Data:

- **Carrier Statement dated 12/29/05, 3 pages.**
- **Receipt of Request dated 12/2/05, 1 page.**
- **Notification of IRO Assignment dated 12/2/05, 1 page.**
- **Medical Dispute Resolution Request dated 11/3/05, 1 page.**
- **List of Treating Providers (date unspecified), 3 pages.**
- **Functional Capacity Assessment dated 11/1/05 dated 2/9/05, 4 pages.**
- **Report of Medical Evaluation dated 9/30/05, 1 page.**
- **Designated Doctor Evaluation dated 9/30/05, 6 pages.**
- **Imaging Report/Consultation dated 8/31/05, 2 pages.**
- **Imaging Report/Chest and Lumbar Spine dated 8/26/05, 1 page.**
- **Imaging Report/Post Myelogram CT Scan of the Lumbar Spine dated 8/26/05, 2 pages.**
- **Required Medical Examination dated 7/28/05, 6 pages.**
- **Explanation of Benefits dated 6/3/05, 5/31/05, 5/25/05, 5/23/05, 5/16/05, 5/12/05, 5/11/05, 5/10/05, 5/4/05, 5/3/05, 4/27/05, 4/25/05, 4/22/05, 4/21/05, 4/18/05, 4/12/05, 4/8/05, 4/4/05, 4/1/05, 3/30/05, 3/28/05, 3/24/05, 3/22/05, 3/21/05, 3/18/05, 3/17/05, 3/14/05, 3/9/05, 3/8/05, 3/3/05, 3/2/05, 2/25/05, 2/23/05, 2/21/05, 2/17/05, 2/16/05, 2/14/05, 8 pages.**
- **Daily Activity Sheet dated 6/13/05, 1 page.**
- **Subsequent Medical Report dated 7/6/05, 5/31/05, 5/3/05, 4/5/05, 3/18/05, 2/3/05, 1/5/05, 14 pages.**
- **Daily Progress Notes dated 6/6/05, 4/18/05, 4/1/05, 2/1/05, 1/17/05, 1/14/05, 12/30/04, 12/8/04, 11/16/04, 11/4/04, 10/21/04, 11 pages.**
- **Exacerbation Letter dated 5/10/05, 1 page.**
- **Physical Therapy Progress Note dated 3/17/05, 12/22/04, 5 pages.**
- **Work Hardening Assessment Psychosocial History dated 2/17/05, 3 pages.**
- **Table of Disputed Services dated 6/3/05, 5/31/05, 5/25/05, 5/23/05, 5/16/05, 5/12/05, 5/11/05, 5/10/05, 5/4/05, 5/3/05, 4/27/05, 4/25/05, 4/22/05, 4/21/05, 4/18/05, 4/12/05, 4/8/05, 4/4/05, 4/1/05, 3/30/05, 3/28/05, 3/24/05, 3/22/05, 3/21/05, 3/18/05, 3/17/05, 3/14/05, 3/9/05, 3/8/05, 3/3/05, 3/2/05, 2/25/05, 2/23/05, 2/21/05, 2/17/05, 2/16/05, 2/14/05, 9 pages.**
- **Initial Medical Report dated 10/21/04, 3 pages.**
- **Motor Nerve Study dated 11/18/04, 3 pages.**
- **Imaging Report/Lumbar Spine dated 11/18/04, 1 page.**

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for: 1) 97140 – Manual therapy. 2) 99212 – Office visit. 3) 97032 – Electrical stimulation. 4) 97110 – Therapeutic exercises. 5) 97112 – Re-education. Dates of service: 2/1/05 through 6/3/05.

Determination: UPHELD - the previously denied request for: 1) 97140 – Manual therapy. 2) 99212 – Office visit. 3) 97032 – Electrical stimulation. 4) 97110 – Therapeutic exercises. 5) 97112 – Re-education. Dates of service: 2/1/05 through 6/3/05.

Rationale:

Patient's age:
Gender:
Date of Injury: ___
Mechanism of Injury: Slip and fall.
Diagnosis: Low back pain.

The claimant is a 53-year-old female injured on ___ when she slipped and fell and reported pain in her low back. She came under the care of Dr. McMillan in October 2004, for complaints of ongoing low back pain with radiation to the left leg. Her straight leg raise was positive, bilaterally, with weak hip flexors and extensors. The claimant also came under the care of Dr. Taylor, DC, in October 2004, who provided joint mobilization, myofascial release, hot/cold, ultrasound and electrical stimulation, as well as exercises. Treatment with him continued into December 2004. The 11/18/04 MRI of the lumbar spine, showed no significant disc bulge or canal stenosis, no foraminal stenosis, and mild disc desiccation at L4-5 and L5-S1. An 11/18/04 electromyogram/nerve conduction velocity (EMG/NCV), reported compromise of the S1 nerve root, similar to lumbosacral radiculopathy of moderate degree. In December 2005, Dr. Patel, DC, provided chiropractic care to the claimant for ongoing complaints of pain in the low back and tingling into the left leg. He treated her periodically in January 2005 into June 2005, noting persistent back pain with tenderness and decreased motion. The claimant also saw Dr. McMillan in 2005 on at least seven occasions. His notes related that the claimant had low back and left leg pain with spasm and positive straight leg raise.

A Functional Capacity Evaluation (FCE) on 02/09/05 noted that the claimant was required to perform a heavy job, but tested at sedentary to light. Dr. Obermiller saw the claimant for a designated doctor examination on 07/28/05 and opined that the EMG of November 2005 did not correlate with her examination or EMG. Straight leg raise was normal, there was no tenderness and sensation was intact. He felt that the claimant had reached maximum medical improvement with a 5 percent impairment rating and had made no progress with treatment. Dr. Obermiller felt that the claimant should be weaned from narcotics and perform home exercises. The 08/26/05 X-rays of the chest and lumbar spine, revealed no pulmonary disease. Disc spaces were preserved and the pedicles were intact. On the 08/26/05 myelogram, there was minor disc bulging at L1-2, L2-3 and a 2mm disc bulge at L3-4 and L4-5. The CT scan showed an extradural indentation at L3-4 and L4-5 due to disc bulging. Dr. Jones performed a designated doctor examination on 09/30/05. Strength was 5/5, and she was able to toe and heel walk. He too, felt she was at maximum medical improvement. On a repeat Functional Capacity Evaluation on 11/01/05, the claimant showed a valid effort and she tested at a sedentary level.

This reviewer cannot recommend the manual therapy, office visit, electrical stimulation, therapeutic exercises or re-education as being medically necessary. The diagnosis was not provided in the data submitted for review, but did appear to be consistent with low back pain and questionable lumbar strain. The injuries sustained in this case constituted a relatively mild musculoskeletal ligamentous injury. Such injuries tend to resolve either with or without treatment over a period of three to four months following the injury. Based upon the orthopedic literature, the training and the professional experience of this reviewer as a Board Certified Orthopedic Surgeon, any clinical benefit that might have been afforded by the passive treatment interventions in question would not have been superior to that of a fully-independent home exercise program by 02/01/05. Clearly, this patient should have been transitioned to a fully-independent home exercise program well before 02/01/05. Thus at this time, this reviewer cannot recommend as reasonable or necessary the interventions requested corresponding to the period from 2/01/05 through 6/03/05.

Criteria/Guidelines utilized: TDI/DWC rules and regulations.

Demeter, Stephen C., Anderson, Gunnar B.J.; Disability Evaluation; second edition.

Official Disability Guidelines, ninth edition, 2004.

Physician Reviewers Specialty: Orthopedic Surgeon

Physician Reviewers Qualifications: Texas Licensed MD, and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.

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.