



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:	MDR Tracking No.: M5-06-0542-01
Nestor Martinez, D.C. 6660 Airline Drive Houston, TX 77076	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
TX Mutual Insurance Company, Box 54	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 package. Position Summary states, "We are in complete compliance with the governing Labor Code and Rules, and we are entitled to full reimbursement of the fees in dispute."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC-60 response. Position Summary states, "Texas Mutual requests that the request for dispute resolution filed 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)
11-9-04 – 2-1-05	CPT code 97140 (\$33.90 X 29 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$983.10
12-7-04	CPT code 97112	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$36.99
11-9-04 – 2-1-05	CPT code 97110 – none in dispute during this time period	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
4-19-05 – 5-31-05	CPT code 97140, 97112, 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$1,020.09.

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 a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$1,020.09. 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:

2-7-06

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.

NOTICE OF INDEPENDENT REVIEW DECISION

February 1, 2006

Program Administrator
Medical Review Division
Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #:
Injured Worker:
MDR Tracking #: M5-06-0542-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a

health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on __. He was pulling a pallet jack which malfunctioned causing the handle to strike his left wrist and causing an injury to that area. The patient was treated with a surgical intervention and aggressive post rehabilitation program.

Requested Service(s)

97140 manual therapy techniques, 97112 neuromuscular re-education, and 97110 therapeutic exercises provided from 11/09/2004 through 05/31/2005.

Decision

It is determined that the 97140 manual therapy techniques, 97112 neuromuscular re-education, and 97110 therapeutic exercises provided from 11/09/2004 through 02/01/2005 were medically necessary to treat this patient's condition.

It is determined that the 97140 manual therapy techniques, 97112 neuromuscular re-education, and 97110 therapeutic exercises provided from 04/19/2005 through 05/31/2005 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

After surgical intervention, the patient began an aggressive post operative rehabilitation treatment program on 10/22/2004. National treatment guidelines allow for this type of treatment for this type of injury. However, the guidelines do not allow for the intensity or frequency this patient received. There is sufficient documentation to clinically justify the manual therapy technique from 11/09/2004 through 02/01/2005. This in essence would represent some three and one half months of a combination of passive therapy with the vast majority of the treatment focusing on active therapy. An MRI was ordered that revealed evidence of a partial thickness tear of the triangular fibrocartilage complex. Follow up report on 04/07/2005 indicated the patient stated he has been doing well from the procedure previously performed and he does not have any particular complaint at this time. Other doctors recommended continued therapy. By this time he had received about 4 months of post-operative rehabilitation and as the records from the surgeon on 04/07/2005 indicate, he had no particular complaint and still the surgeon recommended continued therapy. The surgeon also recommended a EMG although one had already done in January 2005. Based upon national treatment guidelines, the patient had received between 3 and 4 months of post-operative rehabilitation and that is considered an adequate amount. Therefore, all of the disputed services from 11/09/2004 through 02/01/2005 were medically necessary to treat this job injury. The disputed services provided from 04/19/2005 through 05/31/2005 were not medically necessary.

This decision by the IRO is deemed to be a DWC decision and order.

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.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment