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.: M5-06-0581-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company 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: "Therefore, 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)
02-18-05	97032	☐ Yes ☒ No	$0.00
12-04-04 to 03-15-05	97140 ($67.80 X 13 DOS) = $881.40 97140 ($67.88 X 21 DOS) = $1,425.48 97140 ($33.94 X 2 DOS) = $67.88 99212 ($49.41 X 1 DOS) = $49.41 97110 ($71.72 X 6 DOS) = $430.32 97110 ($35.86 X 2 DOS) = $71.72 97112 ($37.78 X 5 DOS) = $188.90	☒ Yes ☐ No	$3,115.11

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 **prevailed** on the **majority** of the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 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 reimbursement in the amount of $3,115.11 . In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of $650.00. 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:

		01-19-06
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.

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:	M5-06-0581-01
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 included:

- MRI lumbar spine report dated 11/1/04;
- Pain & Recovery Clinic of North Houston notes;
- Shanti Pain & Wellness Clinic notes;
- EMG dated 12/2/04;
- IME – Fred L. DeFrancesco, MD;
- Gulf Coast Functional Testing – WCE;
- Designated Doctor Evaluation dated 6/3/04;
- Post Myelogram CT scan of the full lumbar spine from T12-L1 through L5-S1;
- Notes from Jamie Ganc, MD; and
- Mental Health Evaluation – Denise Turboff, M.Ed., LPC dated 10/4/05.

20-year-old male injured at work on ___. Injury was to the lower back. Chronic pain ensued.

REQUESTED SERVICE(S)
Manual therapy techniques (97140), office visits (99212), therapeutic exercises (97110), neuromuscular re-education (97112), and electrical stimulation (97032) from 12/4/04 through 3/15/05.

DECISION
Deny electrical stimulation.

Approve all other services.

RATIONALE/BASIS FOR DECISION
Considering the progress documented, within this questioned time period, the therapy prescribed, except for electrical stimulation, and office visits are appropriate and approved. This decision is based upon the North American Spine Society's Phase III template for the Multi-disciplinary Spine Care Specialist.

According to Drs. Weber and Brown in Braddom's text *Physical Medicine and Rehabilitation*, all therapeutic modalities are considered adjunctive treatments, not primary curative interventions. Therefore, the request for electrical stimulation is denied.

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