



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	
Requestors Name and Address: Health & Medical Practice 324 N. 23 rd Street, Suite 201 Beaumont, Texas 77702	MDR Tracking No.: M5-06-0968-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Southern Vanguard Rep Box # 43	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: Per table of disputed services "Medically necessary".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: We have reviewed the submitted documentation; and feel that our original review was correct. A peer review was performed on the claimants file 9/5/04, in which the reviewing doctor states "an appropriate treatment plan would be a home exercise program of stretching and therapy that would be self directed by the patient." In view of this no further allowance will be recommended.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
02-23-05 to 05-25-05	99213, 97032, 97124, 97530 and 97024	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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:

04-10-06

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
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0968-01
Name of Patient:	
Name of URA/Payer:	Health & Medical Practice
Name of Provider: (ER, Hospital, or Other Facility)	Health & Medical Practice
Name of Physician: (Treating or Requesting)	Patrick McMeans, MD

April 3, 2006

An independent review of the above-referenced case has been completed by a medical physician board certified in neurology. 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: Workers' Compensation dispute and paperwork; JI Specialty Services records table of disputed services; multiple records (frequently duplicated) from Dr. McMeans, James A. Ghadially, MD; lumbar spine epidural steroid injections #1 and #2 reports from Nestor Cruz, MD; EMG report from Meyer L. Proler, MD dated 5/26/04; multiple 'exhibits' from Dr. McMeans; a report of a post myelogram CT of the lumbar spine.

The patient was reportedly injured on ____ when she stepped into a hole in concrete and fell down. There was an elevation in the concrete forward of the hole and she was not able to recover her balance. She fell on to her side and has complained of low back pain continuously since that time. CT myelogram reported disc protrusions or herniations at L2-3, L3-4, and L4-5. EMG of 5/26/04 reported compatible with left L4-S1 radiculopathies.

REQUESTED SERVICE(S)

Office visits (99213), electrical stimulation (97032), massage therapy (97124), therapeutic activities (97530), and diathermy (97024) for dates of service 2/23/05 through 5/25/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

The patient was already declared to be at maximum medical improvement in regard to her low back injury at least as far back as 9/30/04. The lumbar epidural steroid injections were denied. The changes, as described, on the post myelogram CT of the lumbar spine are degenerative in nature. The original injury appears to have been musculoligamentous and would certainly have resolved within the time frame of the MMI. Treatment at this point with ESIs and physical therapy is felt to be treatment for natural progression of her underlying degenerative disease of the spine.

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