



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

<b>Type of Requestor:</b> ( X ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: C-I Medical Group 4425 W. Airport Freeway Suite # 250 Irving, Texas 75062-5800	MDR Tracking No.: M5-07-0185-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Federal Insurance Company Rep Box # 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Specialist consult & objective diagnostic scientific testing necessary due to MRI findings in injured lumbar area, necessary for analysis & decision making on extent of injurious conditions & treatment related to injury. Also necessary to assign future DRE impairment ratings under 4<sup>th</sup> ed. AMA Guides. Reflex changes and radiating pain to gluteals & legs noted in records history."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: No position summary submitted by Respondent.

Principle Documentation: No response submitted to MDR by the Respondent.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-10-05	99245 (* see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$288.00
11-10-05	95861 (* see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$148.00
11-10-05	95903 (1 unit @ \$91.15 X 4 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$364.60
11-10-05	95904 (1 unit @ \$73.16 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$146.32
11-10-05	95934 (1 unit @ \$48.00 X 2 units)(* see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$96.00
	* Note: The Requestor billed at a lower amount than the MAR therefore the amount recommended for payment is the amount billed per Rule 134.202(d)(2)		
	<b>TOTAL DUE</b>		\$1,042.92

#### 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 prevail** on the disputed medical necessity issues.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202(c)(1) and 134.202(d)(2)  
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

**PART VII: DIVISION FINDINGS 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 \$1,042.92. 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 Respondent 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 Order by:

01-09-07

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date of Findings and 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  
Phone: 512-288-3300

Austin, Texas 78735  
FAX: 512-288-3356

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

**REVISED 1/4/07**

TDI-WC Case Number:	
MDR Tracking Number:	M5-07-0185-01
Name of Patient:	
Name of URA/Payer:	C-I Medical Group
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Leo Crowley, MD

December 6, 2006

An independent review of the above-referenced case has been completed by a 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

# REVISED 1/4/07

## DOCUMENTS REVIEWED

1. Notification of IRO Assignment and associated paperwork
2. Medical dispute resolution request/response
3. Medical appeal from Dr. Stephen J. Becker of December 13, 2005
4. EMG report on \_\_\_\_\_ November 10, 2005 from Stephen J. Becker, MD
5. MRI of the lumbar spine on \_\_\_\_\_ from MRI Central Dallas, Texas
6. Initial medical evaluation on \_\_\_\_\_ May 26, 2005 by Dr. Leo Crowley
7. Various follow up chart notes/ evaluations by Dr. Crowley

## CLINICAL HISTORY

This is a 29 year-old female injured on \_\_\_\_ (variously listed). On that date she was working with a 20-pound weightlifting restriction light duty. Previous miscarriage, remote apparently. Still pregnant with a baby. At the time of the Worker's Compensation injury, she lifted a 30-pound tray of silver and sprained her back and pelvis. Felt a pelvic tear and apparently low back pain. She continued to have low back pain and, at the time of the EMG in question, reported low back pain at least into the left lower extremity posteriorly. MRI of the lumbar spine on October 4, 2005 reported mild annular bulge at L4-5 and possible annular fissure at this level.

## REQUESTED SERVICE(S)

99245 office consultation, 95861 needle electromyography, 95903 nerve conduction, 95904 sensory, each nerve, 95934 H reflex study.

## DECISION

Approve

## RATIONALE/BASIS FOR DECISION

At the time of the request for the evaluation, the patient had continued low back pain, apparently radiating into the left lower extremity. There was the report of annular disc bulging and possible annular fissure with the possibility of lumbosacral radiculopathy, electroneuromyography was totally medically indicated and necessary.

### 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, 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.

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