

MDR Tracking Number: M5-05-1011-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-29-04.

The IRO reviewed chiropractic manipulative treatment, spinal 3-4 regions, therapeutic exercises, unlisted physical medicine/rehabilitation service or procedure and range of motion measurements rendered from 07-28-04 through 09-27-04 that were denied based upon "V".

The IRO determined that the chiropractic manipulative treatment, spinal 3-4 regions, therapeutic exercises and range of motion measurements from 07-28-04 through 09-08-04 **were** medically necessary. The IRO determined that the chiropractic manipulative treatment, spinal 3-4 regions, therapeutic exercises and unlisted physical medicine/rehabilitation service or procedure from 09-10-04 through 09-27-04 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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 the Medical Review Division.

On 01-28-05, 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.

Review of CPT codes 98941 and 97110 dates of service 08-27-04 and 08-30-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement recommended.

CPT code 95851 dates of service 06-16-04 and 07-16-04 denied with denial "G" (procedure is included in another procedure performed on same date of service). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service CPT code 95851 was global to. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of \$46.30 ($\$18.52 \times 125\% = \$23.15 \times 2 \text{ DOS}$).

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 06-16-04 through 09-08-04 in this dispute.

This Findings and Decision and Order are hereby issued this 8th day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

January 28, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION Amended Determination 1/28/05

RE: MDR Tracking #: M5-05-1011-01
TWCC #:
Injured Employee:
Requestor: Hill Country Chiropractic
Respondent: Flahive Ogden & Latson
MAXIMUS Case #:

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 54 year-old male who sustained a work related injury on _____. The patient reported that while at work he was installing metal fire doors he injured his back. An MRI of the lumbar spine performed on 6/22/04 revealed a right posterior lateral annular tear and bulge at the L5-S1 level, posterior lateral tear and bulge of the outer annulus at the L4-L5 level, internal disc disruption at the L2-L3 level, and multiple sub-acute healing Schmorl's nodes in the adjacent end plates of L1-2, posterior end plate of L3, and the superior end plates of L4 and L5. The diagnoses for this patient have included cervicobrachial syndrome, brachial radiculitis/neuritis, cervical myofasciitis/myalgia, lumbar plexus disorder, lumbosacral sprain/strain, lumbar neuritis, and lumbar myofasciitis. Treatment for this patient's condition has included chiropractic manipulations, medication, physical therapy, and therapeutic procedures.

Requested Services

Chiropractic manipulative treatment, spinal 3-4 regions, therapeutic exercises, unlisted physical medicine/rehabilitation service or procedure, and range of motion measurements from 7/28/04 through 9/27/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Daily Treatment Notes 4/27/04 – 12/8/04
2. FCE 8/24/04
3. Designated Doctor IRE 9/7/04
4. Examination Note 4/27/04

Documents Submitted by Respondent:

1. IRE 7/28/04

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his back on _____. The MAXIMUS chiropractor reviewer indicated that this patient had a very low level of pain that had slightly improved with treatment during the period 7/28/04 through 9/8/04. The MAXIMUS chiropractor reviewer noted that the patient's pain level had plateaued at 2/10 until 11/24/04. The MAXIMUS chiropractor reviewer explained that at that time the patient's pain level had gone down to a 1/10 and the patient was released to as needed care. The MAXIMUS chiropractor reviewer indicated that the patient had been found to be at maximum medical improvement on 9/7/04. The MAXIMUS chiropractor reviewer explained that the patient did not have a job to return to and that he could have been released to as needed care at that time. The MAXIMUS chiropractor reviewer explained that the patient's treatment did not change and that the patient had plateaued with treatment. Therefore, the MAXIMUS chiropractor consultant concluded that the chiropractic manipulative treatment, spinal 3-4 regions, therapeutic exercises and range of motion measurements from 7/28/04 through 9/8/04 were medically necessary to treat this patient's condition. However, the MAXIMUS chiropractor consultant further concluded that the chiropractic manipulative treatment, spinal 3-4 regions, therapeutic exercises, and unlisted physical medicine/rehabilitation service or procedure from 9/10/04 through 9/27/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department