

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Ramiro Torres c/o Bose Consulting, LLC PO Box 550496 Houston TX 77255	MDR Tracking No.: M5-05-2274-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Rep Box # 19 New Hampshire Insurance Co	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
5-24-04	11-19-04	99211, 99212, 99213, 97032, 97110, 97116, 98940, 97035, 97140, 97112, and E1399	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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 disputed medical necessity issues. The amount due from the carrier is \$5,432.50 plus the DOP amount for the E1399 that is reimbursed per Rule 134.202 (c) (6)).

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 8-8-05 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.

Codes 99213-25 billed on date of service 5-24-04 and 99212-25 billed on date of service 5-26-04 were denied as F, considered integral to the primary procedure billed. There is no CCI rule that indicates an E/M code is bundled into a therapy code. Requestor billed with modifier -25 that indicates a separate identifiable E/M service. Therefore, recommend reimbursement of $\$53.80 \times 125\% = \67.25 plus $\$38.42 \times 125\% = \48.03 for a total of \$115.28.

Code 99080-73 billed on dates of service 7-20-04 and 8-19-04 had no EOBs submitted by either party. The requestor submitted convincing evidence of carrier receipt of request for an EOB. Therefore, this review will be per the 2002 MFG. Recommend reimbursement of $\$15.00 \times 2 \text{ days} = \30.00

Code 99080-73 billed for date of service 9-21-04 was denied as "V - unnecessary medical"; however, per Rule 129.5, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; therefore, recommend reimbursement of \$15.00. The carrier will be billed for inappropriate denial and may also be referred to Compliance & Practices for inappropriate denial of a TWCC required report.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to also remit the amount of \$5592.78 plus DOP amount plus all accrued interest due at the time of payment to the Requestor within 20 days of receipt of this Order.

Findings & Decision by:

8-12-05

Authorized Signature

Typed Name

Date

Ordered by:

Medical Necessity Team

8-12-05

Authorized Signature

Typed Name

Date

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005 should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

August 4, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION (8/9/05)

RE: MDR Tracking #: M5-05-2274-01
TWCC #:
Injured Employee: _____
Requestor: Ramiro Torres c/o Bose Consulting LLC
Respondent: New Hampshire Ins c/o Hartford/SRS
MAXIMUS Case #: TW05-0135

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 32 year-old male who sustained a work related injury to his lower back on _____. A MRI of the patient's lumbar spine performed on 9/23/03 revealed a 2 to 3mm left lateral disc herniation at L4-5 with a posterior annular tear and a 3mm central but somewhat broad based disc herniation at L5-S1 with what appeared to be a horizontal tear of the posterior annulus. Diagnoses for this patient's condition have included radiculopathy, herniated disc, facet joint neuritis, lumbar and cervical disc syndrome, and bilateral sacroiliac joint arthritis and neuritis. Treatment for the patient's condition has included lumbar epidural steroid injections, a facet nerve block at 4 levels along with a left sacroiliac nerve block and post injection rehabilitation.

Requested Services

Office visits 99211, 99212 and 99213, electrical stimulation 97032, therapeutic exercises 97110, gait training 97116, chiropractic manipulation 98940, ultrasound 97035, miscellaneous DME E1399, manual therapy technique 97140 and 97112 from 5/24/04 to 11/19/04.

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

Documents Submitted by Requestor:

1. Position statement
2. Report from a MRI of the lumbar spine performed on 9/23/03
3. Report from an x-ray of the lumbar spine performed on 9/23/03
4. EMG reports dated 12/18/04

5. Report from a Functional Capacity Examination performed on 11/2/04
6. Orthopedic records from 6/23/04 to 7/7/04
7. Reports from lumbar epidural steroid injections performed on 11/7/03, 11/21/03, 12/12/03/30/04, 8/13/04 and 8/27/04
8. Report from facet joint nerve blocks and left sacroiliac joint block performed on 1/16/04 and 1/30/04
9. Pain management consultation report dated 9/2/03
10. Designated Doctor Evaluation report dated 1/9/04
11. Physical therapy initial evaluation dated 10/28/03
12. Physical therapy progress notes dated 11/25/03
13. Initial medical report dated 11/15/04
14. Progress notes dated 9/2/03 to 11/9/04
15. SOAP notes dated 5/19/04 to 11/19/04

Documents Submitted by Respondent:

1. None submitted

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a 32 year-old male who sustained a work related injury to his lower back on _____. The MAXIMUS chiropractor reviewer also noted that this patient has been diagnosed with herniated discs at L4-5 and L5-S1, radiculopathy, facet joint neuritis, lumbar and cervical disc syndrome and sacroiliac joint arthritis. The MAXIMUS chiropractor reviewer indicated that although the patient's response to treatment was slow, the clinical information submitted for review documents objective and subjective evidence of his improvement with treatment. The MAXIMUS chiropractor reviewer explained that given this patient's injury and diagnoses, he responded well to this treatment.

Therefore, the MAXIMUS physician consultant concluded that the office visits 99211, 99212 and 99213, electrical stimulation 97032, therapeutic exercises 97110, gait training 97116, chiropractic manipulation 98940, ultrasound 97035, miscellaneous DME E1399, manual therapy technique 97140 and 97112 from 5/24/04 to 11/19/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Lisa K. Maguire, Esq.
Project Manager, State Appeals