

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 A Glen Haywood DC PO Box 242 Mabank TX 75147	MDR Tracking No.: M5-05-2381-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Rep Box # 19 American Home Assurance	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		
5-13-04	1-5-05	G0283, 99212-25, 99212, 98940, 95831, 95851, 97012, 97110	<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 for the medical necessity issues equals \$2,372.92 minus \$106.52 for codes 95831 and 95851 – CCI components of 98940 and are never paid separately, for a total of \$2,266.40.

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 6-9-05 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.

Code 98940 billed for dates of service 5-13-04 to 7-20-04 and 7-26-04 to 10-7-04 had no EOB submitted by either party. Requestor submitted proof of carrier receipt of request for EOB. Therefore, these DOS will be reviewed per the 2002 MFG.

- 98940 – MAR is $\$25.08 \times 125\% = \$31.35 \times 57 \text{ DOS} = \$1,786.95$

Code 99080-73 billed for date of service 9-22-04 was denied as "U, unnecessary treatment". However, 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 per Rule 129.5. The carrier will be billed for inappropriate denial and may be referred to Compliance and Practices for the 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 \$4,068.35 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 en español acerca de esta correspondencia, favor de llamar a 512-804-4812.

July 22, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION (8/5/05)

RE: MDR Tracking #: M5-05-2381-01
TWCC #:
Injured Employee: ____
Requestor: A. Glen Hatwood, D.C.
Respondent: American Home Assurance/ARCFI
MAXIMUS Case #: TW05-0122

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 44 year-old female who sustained a work related injury to her back on _____. Her initial diagnosis was lumbar strain. Other diagnoses for her condition are lumbar radiculitis, somatic dysfunction, bilateral sacriolitis and chronic pain. Treatment for the patient's condition has included physical therapy, work conditioning/work hardening, medications, a neuromuscular stimulator and injections. An MRI of the patient's lumbosacral spine performed in March 2004 revealed a 3 mm disc protrusion that compressed the thecal sac at L4-5.

Requested Services

G0283 Electrical stimulation, 99212-25 office visit, 98940 chiropractic manipulative treatment – spinal, 95851 range of motion measurement – each, 99212 office visit, 97012 mechanical traction, 97110 therapeutic exercises and 95831 muscle testing, manual (separate procedure) with report from 5/13/04 to 1/5/05.

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

Documents Submitted by Requestor:

1. Letter regarding the request dated 6/20/05
2. Chiropractic treatment records from 11/22/03 to 1/5/05
3. Report from a neurosurgical consultation performed on 10/28/04
4. Medical record dated 9/8/04
5. PRM examination report dated 12/13/04

6. Reports from a designated doctor examination performed on 12/22/04, 3/28/05 and 5/25/05
7. Orthopedic surgeon's records from 3/10/05 to 4/28/05
8. Prescription for a chronic pain program
9. Physical Performance Evaluation report dated 3/24/05
10. Report from a CT performed on 3/25/05
11. Initial pain management consultation report dated 3/31/05

Documents Submitted by Respondent:

1. Independent review organization summary dated 6/21/05
2. Denial letters dated 8/31/04 to 1/3/05
3. Employer's first report of injury or illness
4. Emergency room records dated 12/2/03 to 12/3/03
5. Primary care physician records dated 12/4/03 to 12/15/03
6. Report from a lumbar spine MRI dated 12/20/03
7. Physical therapy progress notes from 12/29/03 to 2/27/04
8. Medical records dated 1/6/04 to 4/23/04
9. Investigator's reports dated 3/18/04 and 4/2/04
10. Report from a functional capacity examination performed on 4/12/04
11. Chiropractic treatment records from 5/12/04 to 3/8/05
12. PPE report dated 6/1/04
13. Medical record dated 9/8/04
14. Report from a neurosurgical consultation performed on 10/28/04
15. Request for consideration from the patient's chiropractor dated 11/19/04
16. Requests for reconsideration dated 11/30/04 to 3/14/05
17. Reports from a designated doctor examinations performed on 12/22/04, 3/28/05 and 5/25/05, and follow-up report dated 4/27/05
18. Orthopedic surgeon's records from 3/10/05 to 4/28/05
19. Report from a CT performed on 3/25/05
20. Initial pain management consultation report dated 3/31/05
21. Physical therapy notes from 12/24/03 to 5/5/05

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 44 year-old female who sustained a work related injury to her back on _____. The MAXIMUS chiropractor reviewer explained that the patient responded to the treatment she received from 5/13/04 to 1/5/05, but that her response was slow. The MAXIMUS chiropractor reviewer also explained that she was able to return to work despite continued pain and disability. The MAXIMUS chiropractor reviewer indicated that the records from this treatment document objective measures of her response to treatment.

Therefore, the MAXIMUS physician consultant concluded that the G0283 Electrical stimulation, 99212-25 office visit, 98940 chiropractic manipulative treatment – spinal, 95851 range of motion measurement – each, 99212 office visit, 97012 mechanical traction, 97110 therapeutic exercises and 95831 muscle testing, manual (separate procedure) with report from 5/13/04 to 1/5/05 were medically necessary to treat this patient's condition.

Sincerely,

MAXIMUS

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