

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X)HCP ()IE ()IC	Response Timely Filed? ()Yes (X)No
Requestor's Name and Address Richard Stephenson DC 322 N. Main Bryan TX 77803	MDR Tracking No.: M5-05-2536-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Rep Box # 28 Liberty Mutual Insurance	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		
7-9-04	11-12-04	99213, 97035, 97124, G0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input checked="" 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 did **not** prevail on the disputed medical necessity issues.

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 6-25-05 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 97124 and 99213 billed 7-28-04 and 7-30-04 and code 99080-73 billed on 7-30-04 had no EOB submitted by either party. The requestor submitted convincing evidence of carrier receipt of request for EOB. Therefore, this review will be per the 2002 MFG. Recommended reimbursement of $\$21.02 \times 125\% = \$26.28 \times 2 \text{ units} = \$52.56 \times 2 \text{ days} = \$105.12 + \$50.00$ (as billed) $\times 2 \text{ days} = \$100.00 + \$15.00 = \220.12 .

Code 99080-73 billed on date of service 11-10-04 and 11-11-04 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 x 2 days = \$30.00.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement of \$250.12 for the fee issues involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Authorized Signature

Typed Name

8-26-05

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 ésta correspondencia, favor de llamar a 512-804-4812.

August 23, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2536-01
TWCC #: ____
Injured Employee: ____
Requestor: Richard Stephenson, DC
Respondent: Liberty Mutual Fire Insurance
MAXIMUS Case #: TW05-0150

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 49-year old female who sustained a work related injury on _____. The patient reported she was transferring a tray from one line to another when she lost her footing and stumbled falling onto her right knee and injuring her left shoulder. Treatment has included surgery, medications, physical therapy and chiropractic services. Diagnoses include left

shoulder rotator cuff sprain/strain, left thumb sprain/strain, right knee sprain/strain, left knee sprain/strain, and contusions. Office visits, ultrasound, massage, and electrical stimulation were provided from 7/9/04 to 11/12/04 for treatment of this patient's condition.

Requested Services

99213 – OV, 97035 – Ultrasound, 97124 – Massage, G0283 – Electrical Stimulation from 7/9/04 to 11/12/04.

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

Documents Submitted by Requestor:

1. SOAP Notes from 6/27/03-6/23/04
2. DME Description and pricing information – 6/27/03-4/23/04
3. Referral Requests – 1/8/04-4/12/04
4. Prescriptions for Therapy – 2/26/04-4/20/04
5. Designated Doctor Evaluation – 7/13/04
6. The Back & Joint Clinic Records – 6/27/03-4/29/04
7. Lone Star Orthopedic Records – 1/5//04-6/21/04
8. Maximum Medical Improvement and Impairment Rating Evaluation – 11/11/03
9. MRI Report – 1/16/04
10. Bryan Neurology Service – 1/27/04
11. Electromyography Report – 1/27/04
12. Operative Reports – 2/6/04, 2/28/04
13. Treatment Plan & Exercise Grids – 1/15/04-4/30/04
14. Procedures Charts– 5/5/03-6/23/04
15. Pain Management Notes – 7/9/04-5/2/05
16. Letter from Marcy Halterman, DC, JC – 10/25/04
17. Exam Sheet, Diagram of Surface Muscles, Case History, Diagnosis Sheet – 7/9/04
18. Comprehensive HealthCare Associates Letter – 4/15/05

Documents Submitted by Respondent:

1. None

Decision

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

Rationale/Basis for Decision

MAXIMUS CHDR chiropractic consultant indicated that the patient was injured in ___ and received passive and active treatments through the end of that year. MAXIMUS CHDR chiropractic consultant noted she had surgery to her left shoulder and left knee in February 2004 and completed postoperative rehabilitation. MAXIMUS CHDR chiropractic consultant explained that the dates of service in question are 15 weeks from the last surgery date. MAXIMUS CHDR chiropractic consultant also indicated according to the National Spine Society

Guidelines for unremitting pain, this patient was in the tertiary phase of care. MAXIMUS CHDR physician consultant indicated that this phase of care includes situations in which there is a documented history of persistent failure to respond to non-operative and/or operative treatment that surpasses the usual healing period of more than 4-6 months post injury and or post surgery. MAXIMUS CHDR chiropractor consultant noted that the types of treatment indicated in the tertiary phase of care include chronic pain management, functional restoration, pharmacological pain control, and injection procedures. MAXIMUS CHDR chiropractor consultant explained that the treatment received by this patient from 7/9/04 to 11/12/04 was appropriate for treatment of the initial phase of care, not for the tertiary phase of care. (Guidelines to Unremitting Pain. National Spine Society, 2002)

Therefore, the MAXIMUS chiropractor consultant concluded that the 99213 – office visits, 97035 – ultrasound, 97124 – massage, G0283 – electrical stimulation from 7/9/04 to 11/12/04 were not medically necessary for treatment of this patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department