



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-05-2660-01
Richard Stephenson DC 322 N. Main St Bryan TX 77803	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
TML Intergovernmental Risk Pool Box 19	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package, EOBs, CMS-1500s. Position summary states in part, "...this care listed above, as evidenced by my documentation satisfied without limit the following bases of medical necessity as set forth in Texas labor Code...and further complies with the legal responsibilities of Treating Doctors/providers rendering care..."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 response. Position Summary: The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. Further, the documentation submitted by the provider provided does not establish medical necessity.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
6-7-04 to 1-13-05	98940	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$30.00
	99213 (\$50.00 x 7 days = \$350.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$350.00
	97750	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$34.30
	TOTAL	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$414.30

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 disputed dates of service 5-21-04 to 6-4-04 are untimely and ineligible for review per Rule 133.308(e)(1).

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues.

Based on review of the disputed issues within the request, Medical Review 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 Medical Dispute Resolution.

On 7-8-05, Medical Review submitted a Notice to the 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 99080-73 billed for dates of service 8-13-04, 11-12-04, and 12-04-04 was denied as unnecessary medical; however, per Rule 129.5, this is a required report and is not subject to an IRO review. Medical Review has jurisdiction in this matter; therefore, recommend reimbursement of \$15.00 x 3 days = \$45.00.

On 11-15-05, the requestor submitted a withdrawal letter for code 99199 billed on 1-4-05; therefore, this will not be reviewed.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.307, 134.202, 129.5

PART VII: DIVISION DECISION 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 additional reimbursement in the amount of \$459.30. 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 \$460.00. The Division hereby **ORDERS** the insurance carrier 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.

Ordered by:

_____, Medical Dispute Officer

_____, 11-18-05

Authorized Signature

Typed Name

Date of 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.

November 16, 2005
October 24, 2005

Texas Department of Insurance, Division of Workers Compensation
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

Amended NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2660-01
DWC #:
Injured Employee:
Requestor: Richard Stephenson, DC
Respondent: TML Intergov Risk Pool
MAXIMUS Case #: TW05-0143

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308 which allows for a dispute resolution by an IRO.

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 who is on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that 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, was signed. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 45-year old male who sustained a work related injury on _____. The patient reported that he sustained an injury to his back while shoveling asphalt off a truck while working with a city road crew. He also reported that he developed back pain with left leg radiation. Diagnoses included lumbosacral strain/sprain, sciatica and myositis. Evaluation and treatment has included MRI, x-rays, lumbosacral support belt, analgesic balm, physical medicine consultation, and chiropractic treatment.

Requested Services

98940-Chiropractic Manipulative Treatment, 99213-Office Visit, 97750-Physical Performance Test from 6/7/04-1/13/05.

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

Documents Submitted by Requestor:

1. Dispute Position – 5/9/05
2. Office Notes from 5/21/04-1/13/05
3. Review Opinion – 4/6/04

4. Retrospective Utilization Review Report – 2/25/04
5. Request for Reconsideration – 1/20/05

Documents Submitted by Respondent:

1. Statement of Carrier's Position – 6/24/05
2. Retrospective Utilization Review Report – 2/25/04
3. Review Opinion – 4/6/04
4. Rationale for Denial of Services Memo – 6/20/05

Decision

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

Rationale/Basis for Decision

MAXIMUS CHDR physician consultant indicated that after review of the medical records provided, it is found that the office visits, physical performance evaluation and chiropractic manipulation were medically necessary to treat the member. MAXIMUS CHDR physician consultant noted that according to the North American Spine Society's phase III clinical guidelines for multidisciplinary spine care specialists regarding unremitting low back pain, this member was in the tertiary phase of care between the dates 6/7/04-1/13/05. MAXIMUS CHDR physician consultant explained that during this phase of care, treatment interventions can include limited passive modalities, injection procedures, functional restoration, manual therapy and additional diagnostic/functional testing. MAXIMUS CHDR physician consultant also indicated that the treatment, testing and office visits from 6/7/04-1/13/05 were medically necessary to treat this patient's condition.

Therefore, the MAXIMUS physician consultant concluded that the 98940-Chiropractic Manipulative Treatment, 99213-Office Visit and 97750-Physical Performance Test from 6/7/04-1/13/05 were medically necessary for treatment of this patient's condition.

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 (other than a spinal surgery prospective 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department