



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: Valley Spine Medical Center 5327 South McColl Road Edinburg, Texas 78539	MDR Tracking No.: M5-05-2946-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 package, CMS 1500s, medical documentation and explanations of benefits
POSITION SUMMARY: No position summary submitted by the Requestor

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: This dispute involves the carrier's payment for date of service 9/30/2004 to 11/19/2004. The requester billed \$5,634.50; Texas Mutual paid \$0.00. The requester believes it is entitled to an additional of \$5,634.50.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
10-12-04 to 11-19-04	97110, 97035, 97124, 97140 and 97113	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,781.20

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 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, 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 Medical Dispute Resolution.

On 08-09-05, 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.

CPT codes 99080-73, 73510, 72100, 99205, 97535, G0283, 97124, 97035, 97110, 97140, 99212, 97113 and HCPCS code E1399 dates of service 09-30-04 through 10-21-04 denied with denial codes "K/287" (Not applicable HCP/Service denied because the doctor is not on the Texas Approved Doctors List (ADL) for this date of service). Services were performed by Dr. Esmeralda Gracia. A review was done and it was confirmed that Dr. Gracia was on the Texas Approved Doctors List (ADL) for the aforementioned dates of service. Reimbursement is recommended in the amount(s) listed below.

99080-73	\$15.00
73510	\$39.01
72100	\$43.59
99205	\$205.39
E1399	\$33.50 (\$18.50 plus \$15.00)
97535	\$35.00
G0283	\$14.41
97124	\$26.28
97035	\$15.84
97110	\$324.00 (\$108.00 X 3 DOS)
97140	\$204.78 (\$68.26 X 3 DOS)
99212	\$97.98 (\$48.99 X 2 DOS)
97113	\$480.00 (\$160.00 X 3 DOS)

CPT code 97124 dates of service 10-01-04, 10-04-04, 10-06-04 and 10-08-04 denied with denial codes "F/435" (Fee Guideline MAR reduction/the value of this procedure is included in the value of the comprehensive procedure). Per the 2002 Medical Fee Guideline code 97124 is a component procedure of code 97140 also billed on the dates of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. No reimbursement recommended.

CPT code 97110 dates of service 10-13-04, 10-14-04, 10-25-04, 10-27-04 and 10-29-04 denied with denial codes "F/435/891" (Fee Guideline MAR reduction/ the value of this procedure is included in the value of the comprehensive procedure). Per the 2002 Medical Fee Guideline code 97110 is a component procedure of code 97113 billed on the dates of service in dispute. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The Requestor did not bill the services with a modifier. No reimbursement recommended.

CPT code 97113 dates of service 10-25-04, 10-27-04 and 10-29-04 denied with denial codes "F/891" (Fee Guideline MAR reduction/ the value of this procedure is included in the value of the comprehensive procedure). Per the 2002 Medical Fee Guideline code 97113 is not included in the value of the comprehensive procedure billed on these dates of service. Reimbursement is recommended in the amount of **\$360.00 (\$120.00 X 3 DOS)**.

CPT code 97140 dates of service 10-25-04, 10-27-04 and 10-29-04 denied with denial codes "F/891" (Fee Guideline MAR reduction/ the value of this procedure is included in the value of the comprehensive procedure).). Per the 2002 Medical Fee Guideline code 97140 is not included in the value of the comprehensive procedure billed on these dates of service. Reimbursement is recommended in the amount of **\$102.39 (\$34.13 X 3 DOS)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 134.202(c)(1)

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 \$4,778.37. 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:

11-03-05

Authorized Signature

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.

MAXIMUS®

HELPING GOVERNMENT SERVE THE PEOPLE®

August 25, 2005

VIA FACSIMILE

Texas Workers' Compensation

Attention: ____

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2946-01
TWCC #: ____
Injured Employee: ____
Requestor: Valley Spine Medical Center
Respondent: Texas Mutual
MAXIMUS Case #: TW05-0168

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 35-year old male who sustained a work related injury on _____. The patient reports that he fell at work on a wet floor sustaining injuries to his right hip, elbow, and right shoulder. He reported that his pain in the lower back had worsened. Diagnoses have included lumbar sprain/strain, hip sprain/strain and muscle spasms. Treatment has included therapeutic exercise, neuromuscular re-education, office visits, manual therapy technique, gait training, and supplies/materials from 3/2/04-12/16/04.

Requested Services

Therapeutic exercise – 97110, ultrasound – 97035, massage therapy – 97124, manual therapy technique – 97140 and aquatic therapy – 97113 from 10/12/04-11/19/04

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

Documents Submitted by Requestor:

1. Request for Reconsideration – 12/30/04, 2/2/05
2. Valley Spine Medical Center Initial Medical Narrative Report – 9/30/04
3. Valley Spine Medical Center Initial Medical Report – 10/5/04
4. Valley Spine Medical Center Examination – 10/15/04, 11/23/04, 12/28/04
5. Valley Spine Medical Center Progress Reports – 10/1/04-11/19/04
6. Therapeutic Procedure Chart – 10/12/04-11/19/04
7. Aquatic Therapy Records – 10/13/04-10/21/04
8. Churchill Evaluation Center Report of Medical Evaluation – 2/24/05

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 consultant explained that according to the medical records, the patient injured his low back and right hip in _____. The MAXIMUS chiropractor consultant indicated that according to the National Spine Society's guidelines for multi-disciplinary spine care specialists regarding unremitting low back pain, the tertiary phase of care that was 8-18 weeks beyond injury includes passive modalities, manual therapy, and massage therapy as clinically indicated interventions. The MAXIMUS chiropractor consultant noted that the number of visits in question are also within the American College of Occupational and Environmental Medicine guidelines for chiropractic care for lumbar spasm/strain

injuries. The MAXIMUS chiropractic consultant explained that all treatment from 10/12/04-11/19/04 were medically

necessary to treat this patient's condition. (American College of Occupational and Environmental Medicine Disability Guidelines, 2004. Guidelines for multidisciplinary spine care specialists, National Spine Society, 2002.)

Therefore, the MAXIMUS chiropractor consultant concluded that the therapeutic exercise – 97110, ultrasound – 97035, massage therapy – 97124, manual therapy technique – 97140 and aquatic therapy – 97113 from 10/12/04-11/19/04 were medically necessary for treatment of this patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department