



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.: M5-05-2949-01
Santiago Guajardo DC 3303 W FM 1960, Suite 360 Houston TX 77068	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Service Lloyds Insurance c/o Harris & Harris Box 42	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 package, EOBs, CMS-1500s.
Position Summary: Treatment medically necessary for extent of injury (herniated lumbar disc, positive nerve testing and post facet injection rehabilitation) TX Labor Code Sect 408.021 date of injections: 6-24-04 7-1-04 8-5-04 and 8-19-04.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 response.
Position Summary: None submitted.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
6-11-04 to 7-7-04	Untimely dates of service	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ 0.00
7-9-04 to 9-3-04	97110 (4 units), 97140, 99213, 99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$3,456.10
7-9-04 to 9-3-04	97110 all units after 4	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$ 0.00

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 majority of the disputed medical necessity issues. The amount due from the insurance carrier for these medically necessary issues is \$3,456.10.

- 97110 = \$29.63 x 125% = \$37.04 x 4 units = \$148.16 x 16 days = \$2,370.56.
- 97140 = \$27.13 x 125% = \$33.91 x 6 days = \$203.46
- 99213 = \$53.80 x 125% = \$67.25 x 10 days = \$672.50
- 99214 = \$83.83 x 125% = \$104.79 x 2 days = \$209.58

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.

Code 99080-73 billed for dates of service 8-2-04 and 9-3-04 was denied as “W9, – 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. The carrier will be billed for inappropriate denial.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 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 \$3,486.10. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$460.00). The Division hereby **ORDERS** the insurance carrier to remit these amounts plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Ordered by:

Dee Z Torres, Medical Dispute Officer

9-29-05

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.

MAXIMUS®

HELPING GOVERNMENT

August 19, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2949-01
TWCC #: ____
Injured Employee: ____
Requestor: Santiago Guajardo, DC
Respondent: Service Lloyds Insurance
MAXIMUS Case #: TW05-0160

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 42-year old male who sustained a work related on _____. The patient reported that while lifting a block of iron weighing approximately 100 pounds to a table, he had to bend with the object in his hand. He reported that he felt immediate low back pain with a sharp popping sensation. An MRI report dated 3/3/04 reported diffuse disc protrusion at L5-S1. His diagnoses included discogenic low back, degenerative disc disease, mechanical back with radiculopathy and lumbar facet arthropathy. His treatment has included medications, intra-articular facet joint injections, office visits, manual therapy techniques, and therapeutic exercise from 7/9/04-9/3/04.

Requested Services

Office visits, manual therapy techniques, and therapeutic exercise from 7/9/04-9/3/04

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

Documents Submitted by Requestor:

1. Psychological Evaluation – 8/25/04
2. Regional Specialty Clinic Records – 3/10/04-8/11/2/04
3. EMG/NCV Reports – 4/15/04, 12/8/04
4. David E. Tomaszek, MD Records – 4/26/04
5. Designated Doctor Evaluations – 4/28/04, 12/16/04
6. MRI – 3/3/04
7. Operative Reports – 6/24/04, 7/1/04, 8/5/04
8. Prescriptions for Physical Therapy – 6/25/04, 8/5/04, 8/19/04, 8/25/04

9. Chiropractic Records – 6/11/04-9/3/04
10. Functional Capacity Evaluation – 8/23/04
11. Summary of Retrospective/Concurrent Review – 4/26/04

Documents Submitted by Respondent:

1. None

Decision

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

Rationale/Basis for Decision

MAXIMUS CHDR physician consultant indicated the patient had a series of facet injections from July 2004 through August of 2004 with his treating doctor performing post injection therapy after each course of injections. MAXIMUS CHDR physician consultant noted that the North American Spine Society Guidelines for multi-disciplinary spine care specialists, facet injections are appropriate in the tertiary phase of care in conjunction with limited active treatment. MAXIMUS CHDR physician consultant explained that the records show that the patient was receiving up to 1½ hours of therapeutic exercise per day. MAXIMUS CHDR physician consultant also indicated that this does not meet the limited active treatment definition. MAXIMUS CHDR physician consultant noted that exercise over one hour was excessive, especially given that the patient previously completed a physical therapy regimen in the initial phase of care. (Guidelines for Multidisciplinary Spine Specialists. NASS, 2002)

Therefore, the MAXIMUS physician consultant concluded that the office visits and manual therapy techniques and therapeutic exercise up to 4 units per visit were medically necessary for treatment of this patient's condition from 7/9/04-9/3/04. The MAXIMUS physician consultant also concluded that therapeutic exercise beyond 4 units per visits from 7/9/04-9/3/04 were not medically necessary for treatment of this patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department