



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.: M5-05-3031-01
Horizon Health c/o Bose Consulting LLC PO Box 550496 Houston TX 77255	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
Eagle Pacific Ins Box 29	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position Summary: Medically necessary

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 response. Position Summary: Unnecessary treatment with peer review

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
7-15-04 to 9-1-04	97110, 97112, 99212, 99213, 97140, 97116, 99070	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
9-2-04 to 12-16-04	97110 x 27 days = \$4,815.20 97112 x 27 days = \$987.05 99212 x 25 days = \$1,200.75 99213 x 3 days = \$201.75 97140 x 27 days = 915.57 97116 x 27 days = \$851.85 99070 x 1 day (DOP)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$8,972.17 plus DOP code

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 3-2-04 through 7-13-04 are untimely and ineligible for review per DWC Rule 133.308 (e)(1).

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the majority of the disputed medical necessity issues. For DOP codes, Subsection 134.202 (c) (6) of the MFG requires carriers to "assign a relative value, which may be based on nationally recognized published relative value studies, published (DWC) medical dispute decisions, and values assigned for services involving similar work and resource commitments." The MAR for 99070 is the amount assigned by the carrier that is consistent with the requirements of this rule.

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 8-4-05, 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 9-29-04 and 11-23-04 was denied as "V – unnecessary medical"; however, per Rule 129.5, the DWC-73 is a required report and is not subject to an IRO review. Medical Review has jurisdiction in this matter. The IRO decision states that office visits from 9-2-04 to 12-16-04 are medically necessary; therefore, these work status reports are medically necessary. Per Rule 133.308(p)(5), the IRO decision is a Division decision. Recommend reimbursement of \$15.00 x 2 days = \$30.00.

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 \$9002.17 plus DOP code. 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.

Findings & Decision by:

Medical Dispute Officer

12-30-05

Authorized Signature

Typed Name

Date

Ordered by:

Associate Director

12-30-05

Authorized Signature

Typed Name

Date

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.

December 15, 2005
September 29, 2005

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

AMENDED NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-3031-01

DWC #:

Injured Employee:

Requestor: Horizon Health c/o Bose Consulting

Respondent: Eagle Pacific Ins. Co./Seabright Insurance Company

MAXIMUS Case #: TW05-0167

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 that 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 on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. This case was also reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. This physician is board certified in neurosurgery. The reviewers have met the requirements for the approved doctor list (ADL) of DWC or have been approved as an exception to the ADL requirement. A certification was signed that the reviewing providers have 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 reviewers certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on _____. The patient reported that while lifting a garbage can as a custodian, she developed pain in her left knee. She also reported that the pain was severe and that she had difficulty mobilizing her knee. Diagnoses have included grade II patellar chondromalacia, minimal joint effusion, bilateral meniscal tears and ACL attenuation. Treatment has included surgery, Celebrex, therapeutic exercise, neuromuscular re-education, office visits, manual therapy technique, gait training and supplies/materials.

Requested Services

Therapeutic exercise – 97110, neuromuscular re-education – 97112, office visits 99212/99123, manual therapy technique – 97140, gait training – 97116 and supplies/material – 99070 from 7/15/04 to 12/16/04.

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

Documents Submitted by Requestor:

1. Statement of Medical Necessity – not dated
2. MRI Report – 2/24/04

3. Operative Report – 9/1/04
4. Orthopedic Reports – 6/20/04, 12/16/04, 9/19/04, 11/6/04
5. Medical Reports – 10/7/03, 2/27/04, 1/19/05
6. Daily Notes – 7/1/04-12/21/04
7. Peer Review – 8/30/04
8. Report of Medical Evaluation – 12/23/04

Documents Submitted by Respondent:

1. None provided.

Decision

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

Rationale/Basis for Decision

The MAXIMUS CHDR chiropractor consultant indicated that the member injured her left knee on ___ and began treatment of the knee on 10/7/03. The MAXIMUS CHDR chiropractor consultant noted the member was referred for an MRI of the left knee on 2/24/04 that showed a grade II chondromalacia. The MAXIMUS CHDR chiropractor consultant explained that at that point the member had already received over 8 weeks of physical therapy for her left knee. The MAXIMUS CHDR chiropractor consultant indicated that this amount of treatment was beyond the Official Disability Guidelines for treatment of chondromalacia. The MAXIMUS CHDR chiropractor consultant also explained that treatment from 3/2/04 to 9/1/04 were not medically necessary to treat the member's condition. The MAXIMUS CHDR chiropractor consultant noted the member had surgery on the left knee on 9/1/04. The MAXIMUS CHDR chiropractor consultant indicated the Official Disability Guidelines for post-operative treatment for ACL repairs and menisectomies is 16-weeks of physical therapy. The MAXIMUS CHDR chiropractor consultant explained that treatments from 9/2/04-12/16/04 were medically necessary as post-operative rehabilitation to the claimants left knee. (Disability Guidelines, Work Loss Data Institute, 2005.)

Therefore, the MAXIMUS chiropractor consultant concluded that the therapeutic exercise – 97110, neuromuscular re-education – 97112, office visits 99212/99123, manual therapy technique – 97140, gait training – 97116 and supplies/material – 99070 from 7/15/04 to 9/1/04 were not medically necessary for treatment of this patient's condition. The MAXIMUS physician consultant also concluded that the therapeutic exercise – 97110, neuromuscular re-education – 97112, office visits 99212/99123, manual therapy technique – 97140, gait training – 97116 and supplies/material – 99070 from 9/2/04 to 12/16/04 were medically necessary for treatment of this patient's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department