



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: <b>Todd L Bear DC 1412 Richey Street Pasadena TX 77502</b>	MDR Tracking No.: M5-05-3086-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: <b>Texas Mutual Insurance Box 54</b>	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 package, EOBs, CMS-1500s. No position summary submitted.

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 response. This dispute involves the carrier's payment for date of service 8-4-04 to 9-17-04. The requester billed \$803.00; Texas Mutual paid \$0.00. The requester believes it is entitled to an additional of \$803.00.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-4-04 to 9-17-04	99213, 97035, 97110, 97140, G0283, 97032,	<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 did **not** prevail on the disputed medical necessity issues.

Based on review of the disputed issues within the request, the 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 8-19-05, Medical Review 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.

Code 99214 billed on date of service 9-8-04 was denied as N, TG – documentation does not support the service billed and 151 –this level of service does not meet the components as defined in the CPT book. The requestor submitted a “Subsequent Medical Report” dated 9-8-04. This does not meet the requirements of an office visit 99214. Therefore, no reimbursement recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.202

**PART VII: DIVISION DECISION**

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 not entitled to additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

**Findings and Decision by:**

Medical Dispute Officer

10-31-05

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.**

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

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-05-3086-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Todd Bear**  
**Respondent: Texas Mutual Insurance Company**  
**MAXIMUS Case #: TW05-0178**

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 30-year old female who sustained a work related injury on \_\_\_\_\_. The patient reported that while carrying a box, she stepped on a skateboard and fell onto her back. She also reported neck and low back pain. Diagnoses included a contusion of the lumbar region, cervical strain, spinal myalgia, myositis, sciatica, cervicalgia and dementia due to head trauma. Evaluation and treatment has included x-rays, MRIs, CT scan, office visits, therapeutic exercises, manual therapy, ultrasound and electrical stimulation.

### Requested Services

97110-therapeutic exercises, 97140-manual therapy techniques, 99213 office visits, 97035-ultrasound, G0283-electrical stimulation, 97032-electrical stimulation manual from 8/4/04-9/17/04.

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

*Documents Submitted by Requestor:*

1. Progress Report – 8/2/04, 8/23/04
2. Request for Reconsideration – 6/1/05
3. Subsequent Medical Report – 9/8/04

*Documents Submitted by Respondent:*

1. Concentra Medical Centers Evaluation – 1/19/04
2. Initial Orthopedic Consultation – 2/2/04
3. Designated Doctor Evaluation – 6/19/04
4. Neuropsychological Evaluation – 10/8/04
5. Neurodiagnostic Associates of Houston Examination – 10/14/04

**Decision**

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

**Rationale/Basis for Decision**

MAXIMUS chiropractor consultant indicated the records show the patient was injured on \_\_\_ and she received 5 months of passive and active treatments to her cervical and lumbar spine. MAXIMUS chiropractor consultant explained she was then placed at MMI on 6/19/04. MAXIMUS chiropractor consultant also indicated she was recommended for injections to the lumbar and sacroiliac joint regions were recommended for her. MAXIMUS chiropractor consultant noted additional exercise was also recommended. MAXIMUS chiropractor consultant indicated the patient's initial symptoms, pain level and subjective complaints were virtually identical to her complaints on 6/19/04 at her designated doctor evaluation, with virtually no change in symptoms after 5 previous months of treatment. MAXIMUS chiropractor consultant explained additional exercise was not medically necessary for this reason. MAXIMUS chiropractor consultant indicated that according to the 2004 Official Disability Guidelines, myositis treatment should last up to 8 weeks. MAXIMUS chiropractor consultant explained that this patient was well beyond 8 weeks of treatment.

Therefore, the MAXIMUS physician consultant concluded that the 97110-therapeutic exercises, 97140-manual therapy techniques, 99213-office visits, 97035-ultrasound, G0283-electrical stimulation, and 97032-electrical stimulation manual from 8/4/04-9/17/04 were not medically necessary for treatment of this patient's condition.

Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department