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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:	MDR Tracking No.: M5-05-3200-01
Jack P Mitchell DC **PO Box 9159** **Longview TX 75608-9159**	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
National American Insurance Co Box 02	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: Please see the peer review from Forte along with a position letter.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-16-04 to 12-21-04	98941 ($43.00 x 3 days)	☒ Yes ☐ No	$129.00
	G0283, E0230, A4556	☐ Yes ☒ 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.

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.

Rule 134.202 (b) states that Texas Workers' Compensation system participants shall apply the Medicare program reimbursement coding, billing, and reporting payment policies in effect on the date a service is provided. Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Commission fee guidelines in effect on the date of service.

The requestor billed Code 99214-MP on 8-16-04 and 12-21-04. This modifier is invalid after 8-1-03; therefore, no review and no reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

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 $129.00. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the paid 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 14, 2005
October 18, 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 #: M5-05-3200-01
DWC #:
Injured Employee:
Requestor: Jack P. Mitchell, DC
Respondent: National American Insurance
MAXIMUS Case #: TW05-0202

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 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 female who sustained a work related injury on ___. The patient reported that she sustained injury to her neck and lower back while lifting cases of beer. She reported neck and pain and muscle spasm in her neck with radiation of pain into her shoulder. She also reported neck pain and occipital headaches. Diagnoses have included herniated discs, cervical strain and degenerative disc disease. Evaluation and treatment have included surgery, chiropractic services, MRI, medications and EMG and nerve conduction studies.

Requested Services

Electrical stimulation (G0283), ice cap or collar (E0230), chiropractic manipulation (98941) and electrodes (A4556) from 8/16/04-12/21/04.

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

Documents Submitted by Requestor:

1. Jack P. Mitchell, DC Correspondence – 9/27/05
2. Longview Regional Medical Records – 6/11/01
3. Good Shepard Medical MRI Report – 3/16/01
4. Evaluation by Dr. Zum Brunnen, MD – 12/26/01
5. Chiropractic Evaluation – 10/9/02
6. Designated Doctor Examination – 10/22/02
7. Subjective Diagrams – 3/21/01-12/21/04

8. Request for Reconsideration – not dated
9. TWCC Compliance Letter – 1/23/05
10. Letter of Denial – 2/22/05
11. Doctors Daily SOAP Notes – 11/14/03-12/21/04

Documents Submitted by Respondent:

1. Position Paper – 8/31/05
2. Documentation Review and Opinion – 6/16/03

Decision

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

Standard of Review

This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted the patient underwent surgery on 3/6/02 and was eventually placed at maximum medical improvement on 10/22/02. The MAXIMUS chiropractor reviewer indicated that the dates of service in question are 8/16/04 to 12/20/04. The MAXIMUS chiropractor reviewer noted treatments included electric stimulation, ice cap or collar, manipulations and electrodes. The MAXIMUS chiropractor reviewer explained that according to the North American Spine Society's 2002 clinical guidelines for multipdisciplinary spine care specialists, the patient was in the palliative phase of care during the dates in question. The MAXIMUS chiropractor reviewer indicates the palliative phase of care includes medical maintenance procedures to limit severity of recurrent episodes of pain/disability and medical or non-medical procedures specifically designed to ameliorate chronic pain or disability. The MAXIMUS chiropractor reviewer also noted the types of interventions clinically indicated in the palliative phase of care include medications, injection procedures, vocational rehabilitation, spinal cord stimulator implantation, repeat surgical interventions, repeat diagnostic testing, and limited passive modalities which include manipulations. The MAXIMUS chiropractor reviewer indicated the patient was in the palliative phase of care and complained of chronic exacerbations of her previous injury. The MAXIMUS chiropractor reviewer noted according to the guidelines, the manipulations would be medically necessary to treat the patient's condition. The MAXIMUS chiropractor reviewer explained that however, the electrical stimulation, electrodes, and ice cap or collar were not acceptable interventions in the palliative phase of care and thus not medically necessary to treat the patient's condition. (Clinical Guidelines for Multidisciplinary Spine Care Specialists. North American Spine Society. 2002)

Therefore, the MAXIMUS chiropractor consultant concluded that the chiropractic manipulation (98941) from 8/16/04-12/21/04 was medically necessary for treatment of this patient's condition. The MAXIMUS chiropractor consultant also concluded that the electrical stimulation (G0283), ice cap or collar (E0230) and electrodes (A4556) from 8/16/04-12/21/04 were not 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