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: Summit Rehabilitation Centers 2500 W. Freeway #200 P.O. Box 380395 Ft. Worth, TX 76102	MDR Tracking No.: M5-05-3207-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Zurich Insurance Company, Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "Services were necessary to treat the injured worker."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "The documentation provided does not establish medical necessity."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
3-14-05	CPT code 97750-FC	☒ Yes ☐ No	$618.40
4-19-05 – 4-21-05	CPT codes 97545-WH, 97546-WH	☒ Yes ☐ No	$1,024.00
2-24-05 – 4-21-05	CPT codes 97110, 99204, 99213, A4556, G0283, 97012, 97140-59, 98940, 96004	☐ Yes ☒ No	0

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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is $1,642.40.

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 9-12-05 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.

Regarding CPT code 99213 on 3-22-05 and 4-7-05: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of $136.62 ($68.31 X 2 DOS).

Regarding CPT code 99080-73 on 3-24-05: This service was denied with denial code "V" (based on peer review further treatment is not recommended). The IRO reviewer concluded that the office visit (99213) on date of service 03-24-05 was not medically necessary. Based on Rule 133.308(p)(5) an IRO decision is deemed to be a commission decision and order, therefore no reimbursement is recommended for code 99080-73 either.

Regarding CPT code 99080-73 on 4-25-05: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of $15.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 133.308 and 134.202(c)(1).

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 a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of $.1,794.02. 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 and Decision and Order by:

		12-27-05
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.

December 19, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-3207-01
DWC #:
Injured Employee: ___
Requestor: Summit Rehabilitation Centers
Respondent: American Zurich Inc Co/Flahive-Ogden-Latson
MAXIMUS Case #: TW05-0190

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 performing her usual duties as a warehouse worker she felt immediate pain in her right shoulder and neck when lifting a 50-pound box of clothes. She reported that she dropped the box and was unable to work the rest of the day. Diagnoses include right shoulder strain, back pain, traumatic nerve root irritation, thoracic sprain/strain, traumatic lumbar soft tissue and facet injuries, rotator cuff impingement, cubital tunnel syndrome, and cervical spin sprain. Evaluation and treatment has included chiropractic services, steroid injections, physiotherapy, work hardening, x-rays and an MRI.

Requested Services

Therapeutic exercises-97110, office visits-99204/99213, electrodes-A4556, electrical stimulation-G0283, mechanical traction-97012, manual therapy technique-97140-59, chiropractic manipulative treatment-98940, functional capacity exam-97750-FC, work hardening-97545-WH, work hardening each additional hour-97546-WH and physician review & interpretation of comprehensive computer analysis-96004 from 2/24/05-4/21/05.

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

Documents Submitted by Requestor:

1. Treating Doctor Position Statement – 11/21/05
2. Specialty Evaluations – 4/11/05,

3. Authorization/Denial Notices – 4/19/05, 6/9/05,
4. Physical Exam & Neurological Evaluation – 3/14/05, 5/17/05
5. Ergo's Evaluation and Summary Report – 3/14/05, 5/17/05
6. Clinical SOAP Notes – 2/28/05-6/6/05
7. Psychotherapy Group Note – 4/20/05

Documents Submitted by Respondent:

1. Carrier's Position Statement – 8/31/05
2. Physical & Medicine Review Findings – 3/8/05
3. Angela Patterson & Associates Review Findings – 3/2/05
4. Authorization/Denial Notices – 4/5/05, 4/19/05

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 was injured on ___ and received both active and passive treatments for treatment of her condition. The MAXIMUS chiropractor reviewer indicated that services to the patient included therapeutic exercises, office visits, electrodes, electrical stimulations, mechanical traction, manual therapy, manipulations, functional capacity exams, work hardening and physician review of comprehensive analysis. The MAXIMUS chiropractor reviewer also noted dates of service from 2/24/05-4/21/05 fall within the tertiary phase of care according to the North American Spine Society's Clinical Guidelines for Mulidisciplinary Spine Care Specialists. The MAXIMUS chiropractor reviewer explained clinical indicators for this phase of treatment include documented history of persistent failure to respond to non-operative treatment which surpasses the usual healing period of 4-6 months post injury and inhibition of physical functioning producing failure to match daily living requirements, and an inability to match physical capacity to work requirements. The MAXIMUS chiropractor reviewer indicated the patient underwent a functional capacity evaluation on 3/14/05 that showed that the patient was functioning at a light physical demand level while her job level was a medium demand level. The MAXIMUS chiropractor reviewer noted that she had over one year of previous active and passive treatment with continued symptoms. The MAXIMUS physician reviewer noted that the interventions in the tertiary phase of care include chronic pain management, functional restoration, pharmocologic interventions, injections and nerve root blocks. The MAXIMUS physician reviewer indicated that assessments performed in this phase of care can include mental health assessments, physical capacity evaluations and functional capacity evaluations.

The MAXIMUS physician reviewer also noted that since the patient was in the tertiary phase of care, the therapeutic exercises, electrodes, electrical stimulation, manual therapy, mechanical traction, manipulations and physician review and interpretation of comprehensive computer analysis from 2/24/05-4/21/05 were not medically necessary to treat this patient's condition. The MAXIMUS chiropractor reviewer also explained that the functional capacity examination and work hardening program with additional hours were medically necessary to treat this patient from 2/24/05-4/21/05. (Clinical Guidelines for Multidisciplinary Spine Care Specialists. North American Spine Society. 2000.)

Therefore, the MAXIMUS chiropractor reviewer concluded that the therapeutic exercises-97110, office visits-99204/99213, electrodes-A4556, electrical stimulation-G0283, mechanical traction-97012, manual therapy technique-97140-59, chiropractic manipulative treatment-98940, and physician review & interpretation of comprehensive computer analysis-96004 from 2/24/05-4/21/05 were not medically necessary to treat this patient's condition. The MAXIMUS chiropractor reviewer also concluded that the functional capacity exam-97750-FC and work hardening-97545-WH with additional hours from 2/24/05-4/21/05 were medically necessary to treat this patient's condition.

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.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department