



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.: M5-06-0201-01
Mario A Sanchez DO 106 n Main La Feria TX 78559	Claim No.:
	Injured Worker's Name:
	Date of Injury:
Respondent's Name and Address: TASB Risk Management Fund Box 12	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position summary: none submitted

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package. 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)
10-11-04 to 11-2-04	97139, 99070, 97032, 97016, 97112, 97124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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.

Disputed dates of service 7-12-04 through 7-14-04 are untimely and ineligible for review per Rule 134.308.

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.

Code 97010 billed on dates of service 10-14-04 to 11-2-04 (11 dates) was denied as 'global, hot/cold packs are global, integral, and/or a component of the primary procedure code billed.' Per the 2002 Medical Fee Guideline, hot/cold packs are never reimbursed separately as they are included in the primary procedure billed. No separate reimbursement is 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 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

11-28-05

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.

November 3, 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 #: M5-06-0201-01
DWC #:
Injured Employee:
Requestor: Mario A. Sanchez, D.O.
Respondent: TASB Risk Management Fund
MAXIMUS Case #: TW05-0217

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 physician 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 orthopedic surgery. 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 an adult female who sustained a work related injury on _____. The patient reported that she sustained a work related injury when she was attempting to open a hall door and a student kicked the door from the opposite side. The patient also reported that the door hit her right palm and thumb and pulled her shoulder back. Evaluation and treatment have included MRI, home exercise, physical medicine and rehabilitation services and medication. Diagnoses have included strain of cervical and upper thoracic spine and right shoulder scapular muscle pain.

Requested Services

Unlisted therapeutic procedure – 97139, supplies/materials – 99070, electrical stimulation – 97032, vasopneumatic devices – 97016, neuromuscular re-education – 97112 and massage therapy – 97124 from 10/11/04-11/2/04.

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

Documents Submitted by Requestor:

1. MRI – 7/22/04
2. Progress Notes – 5/5/04-2/22/05

Documents Submitted by Respondent:

1. None submitted.

Decision

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

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 physician reviewer noted that this patient has strains of the upper thoracic right shoulder scapula region. The MAXIMUS physician reviewer indicated the MRI also shows old degenerative changes in the cervical and thoracic spine. The MAXIMUS physician reviewer noted there is no class I data or literature to support the use of an electrical stimulator, massage therapy, unlisted therapeutic procedure or vaso pneumatic devices for these diagnoses. The MAXIMUS physician reviewer explained that these modalities are experimental for this condition. The MAXIMUS physician reviewer indicated that given the lack of support in the peer-reviewed literature, these modalities should be denied as not medically necessary in this case.

Therefore, the MAXIMUS physician consultant concluded that the unlisted therapeutic procedure – 97139, supplies/materials – 99070, electrical stimulation – 97032, vasopneumatic devices – 97016, neuromuscular re-education – 97112 and massage therapy – 97124 from 10/11/04-11/2/04 were not medically necessary for treatment of this patient's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department