



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.: M5-06-0271-01
Kevin Strathdee, D. C. 2121 N. Main St. Ft. Worth, TX 76106	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
TX Mutual Insurance Company, Box 54	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "Medically necessary for active rehabilitation."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

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)
3-11-05 – 6-27-05	CPT code 97035 (\$15.11 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$75.55
3-11-05 – 6-27-05	CPT code 97140 (\$33.04 X 20 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$660.80
3-11-05 – 6-27-05	CPT code 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$34.93
3-11-05 – 6-27-05	CPT code G0283 -The insurance carrier submitted proof that this service had been reimbursed to the requestor.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$771.28.

CPT code 97014-59 on 6-6-05 and 6-14-05 was denied by the carrier as "CAC-16-claim/service lacks information which is needed for adjudication" and "207-Need valid Texas fee guideline code". In accordance with 134.202(b): for billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies. This is not a valid CPT code per the 2002 MFG. In addition, the requestor provided no documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 133.308 and 134.202(b) and (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 carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to additional reimbursement in the amount of \$771.28. 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:

Donna Auby

1-31-06

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.

January 27, 2006

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 #: M5-06-0271-01
DWC #:
Injured Employee: ____
Requestor: Kevin Strathdee, DC
Respondent: Texas Mutual Insurance Company
MAXIMUS Case #: TW05-0226

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 that 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 that 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 an adult male who sustained a work related injury on _____. Records indicate that while working as a press operator, he was lifting a 100-pound weight at stool level that he tried to hold when it slipped. He also reported that he continued to work but noted stiffness and pain. Evaluation and treatment have included an MRI, x-rays, medication, physical therapy and injections. Diagnoses have included sprain/strain, lumbar radiculopathy, post traumatic lumbar disc syndrome, post thoracolumbar facet mediated pain, cervical radiculitis and cervicothoracic myofascial pain syndrome.

Requested Services

Ultrasound (97035), Manual Therapy Technique (97140), Therapeutic Exercises (97110), Electrical Stimulation (G0283) from 3/11/05-6/27/05.

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

Documents Submitted by Requestor:

1. Request for Reconsideration – 8/23/05
2. Occupational Injury Report – 3/8/05

3. Texas Injury Clinic Medical Records and Reports – 3/11/05-6/27/05
4. Diagnostic Study Reports (i.e., MRIs, NCV, etc) – 1/31/05, 4/4/05

Documents Submitted by Respondent:

1. Summary of Carriers Position – 11/21/05
2. Concerntra Medical Centers – 1/12/05-1/17/05
3. Diagnostic Study Reports (i.e., MRIs) – 1/31/05
4. Texas Injury Clinic Medical Records and Reports – 3/10/05-6/27/05
5. Physical Medicine and Rehabilitation Records – 7/7/05

Decision

The Carrier's denial of authorization for the requested services is 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 consultant indicated that expectation of improvement in a patient's condition should be established based on success of treatment. The MAXIMUS chiropractor consultant noted continued treatment is expected to improve the patient's condition and initiate restoration of function. The MAXIMUS chiropractor consultant also noted that if treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. The MAXIMUS chiropractor consultant explained that with documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains. The MAXIMUS chiropractor consultant indicated that in this case, there is adequate documentation of objective and functional improvement in this patient's condition. The MAXIMUS chiropractor consultant explained that specifically, the patient's National Institute for Occupational Safety and Health (NIOSH) lifting capabilities dramatically improved from 03/15/05 (prior to the initiation of the disputed treatment) to 6/1/05 (near the end of the disputed treatment). The MAXIMUS chiropractor consultant also explained that the medical records fully substantiate that the disputed services fulfilled the statutory requirements since promotion of recovery was accomplished. (Texas Labor Code 408.021)

Therefore, the MAXIMUS physician reviewer concluded that the Ultrasound (97035), Manual Therapy Technique (97140), Therapeutic Exercises (97110), Electrical Stimulation (G0283) from 3/11/05-6/27/05 were medically necessary to treat this patient's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department