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.: M5-06-0325-01
Neuromuscular Institute of Texas – PA **9502 Computer Drive, Suite 100** **San Antonio TX 78229**	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
C/o Downs Stanford PC Box 17	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position summary: IW presented to CNIT for consultation, evaluation and treatment. The treating doctor followed-up on 10-13-04 and 1-25-05 for evaluation/management of her compensable injury. The PA provided an office visit prior for evaluation prior to an injection. Post injection therapy (PIT) was provided from 2-15-05 to 3-1-05. PA provided a second injection with an office visit for evaluation prior to injection. IW was treated with PIT from 3-16-05 to 4-8-05.

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)
10-13-04 to 5-12-05	99212, 99213, 99080-73	☒ Yes ☐ No	$904.59
10-13-04 to 5-12-05	97035, 97140-59, G0283	☐ 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 did **not** prevail on the majority of 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 11-8-05, 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 and A4209 billed on 2-15-05 were denied as global. Per the 2002 Medical Fee Guideline, these two codes are global to the surgical procedure (20553) performed on the same day. Per Medicare surgical rules, services provided the day of the procedure are included in the fee schedule amount. Therefore, no additional reimbursement recommended.

Code 99214 and A4209 billed on 3-15-05 were denied as global. Per the 2002 Medical Fee Guideline, these two codes are global to the surgical procedure (20552) performed on the same day. Per Medicare surgical rules, services provided the day of the procedure are included in the fee schedule amount. Therefore, no additional 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 entitled to reimbursement of $904.59 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	12-6-05
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.

December 13, 2005
December 1, 2005

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

AMENDED NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-06-0325-01
DWC #:
Injured Employee: ___
Requestor: Neuromuscular Institute of Texas - PA
Respondent:
MAXIMUS Case #: TW05-0225

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 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 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 female who sustained a work related injury on ___. The patient reported that while typing, she noticed increased pain in her forearms and neck. Evaluation and treatment have included carpal tunnel surgery, injections, chiropractic treatments, electrodiagnostic studies and MRI. Diagnoses have included cervical strain, myofascitis, scalene entrapment, perhipheral neuropathy, entrapment neuropathy, radiculopathy and fiibromyalgia.

Requested Services

Office visits – 99212/99213, special reports – 99080-73, ultrasound – 97035, manual therapy technique – 97140-59, electrical stimulation – G0283 and injection of Bupivicane S0020 from 10/13/04-5/12/05.

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

Documents Submitted by Requestor:

1. Neuromuscular Institute of Texas Position Statement – 11/10/05
2. Neuromuscular Institute of Texas Records – 6/21/99-10/31/05
3. Terry Westerfield, MD Records – 12/10/03-9/8/05
4. Wilber Avant, MD Records – 7/18/05-8/5/05

Documents Submitted by Respondent:

1. Carrier's Position Statement – 11/11/05
2. Peer Review – 4/4/05
3. Operative Report – 12/10/03
4. Pain Management Records – 4/1/03, 9/11/03
5. Neuromuscular Institute of Texas Records – 1/9/04-5/12/05

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 that the records report that the patient was seen for follow-up visits from 10/13/04 and 1/25/05. The MAXIMUS chiropractor reviewer indicated that these office visits were medically necessary to track the patient's progress and symptom assessment. The MAXIMUS chiropractor reviewer also noted the patient had injections with post injection therapy from 2/15/05-5/12/05. The MAXIMUS chiropractor reviewer explained that according to the "Consideration and recommendations regarding myofascial trigger point injections" by Chang-Zern Hong, MD, 1994, Journal of Musculoskeletal Pain, appropriate post injection care includes cold or hot packs, therapeutic exercise and therapeutic massage to help improve muscle tone, strength and flexibility. The MAXIMUS chiropractor reviewer indicated that the ultrasound, electrical stimulation and the manual therapy were not medically necessary to treat this patient's condition from 10/13/04-5/12/05. The MAXIMUS chiropractor reviewer noted the office visits and special reports from 10/13/04-5/12/05 were medically necessary to document any changes in the patient's work status or restriction status.

The MAXIMUS physician reviewer noted that the injection of Bupivicane S0020 from 10/13/04-5/12/05 was not medically necessary for treatment of the member's condition. The MAXIMUS physician reviewer indicated that the use of Bupivicane blocks is considered experimental /investigational in nature. The MAXIMUS physician reviewer also noted that the efficacy of Bupivicane blocks has not been established and therefore these services were not medically necessary for treatment of the member's condition.

Therefore, the MAXIMUS chiropractor reviewer concluded that the Office visits – 99212/99213, special reports – 99080-73 from 10/13/04-5/12/05 were medically necessary for treatment of the member's condition. MAXIMUS chiropractor reviewer also concluded that ultrasound – 97035, manual therapy technique – 97140-59 and electrical stimulation – G0283 from 10/13/04-5/12/05 were not medically necessary for treatment of this patient's condition. In addition, the MAXIMUS physician reviewer concluded that the injection of Bupivicane S0020 from 10/13/04-5/12/05 was not medically necessary for treatment of 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