



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.: M5-06-0451-01
Valley Spine Medical Center 5327 South McColl Rd. Edinburg, Texas 78539	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 form, medical documentation, Explanations of Benefits and CMS 1500's. Position summary states, "Attached you will find medical records for these dates of service. Please note that medical necessity was established in the patient clinical notation. If the health care is medically necessary, then 134.202 requires reimbursement in accordance with the Act and Commission rules."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "The carrier asks that the request for dispute resolution be conducted under the provision 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)
11-8-04 – 4-1-05	CPT code 99212 (6 DOS X \$45.26)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$271.56
11-8-04 – 4-1-05	CPT code 97140 (4 DOS X \$31.73 + 12 DOS X \$31.79)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$508.40
11-8-04 – 4-1-05	CPT code 97110 (10 DOS X \$34.46 + 26 DOS X \$33.56)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,217.16
11-8-04 – 4-1-05	CPT code 97124 (1 DOS X \$26.28 + 1 DOS X \$26.63)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$52.91
3-21-04 – 4-1-05	CPT codes 97035, G0283	<input type="checkbox"/> Yes <input checked="" 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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$2,050.03.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 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 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 \$2,050.03. 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

12-29-05

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 #: M5-06-0451-01
DWC #:
Injured Employee: ____
Requestor: Valley Spine Medical Center
Respondent: Texas Mutual
MAXIMUS Case #: TW05-0233

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 an adult male who sustained a work related injury on _____. The patient reported that he was unloading 80 sacks of gel that weighed about 100 pounds when he felt discomfort when he twisted to sustain a bag in his arms. The patient also reported that he complains of low back pain that radiates to his right side. Evaluation and treatment have included physical therapy, injections, an MRI, and motor and nerve studies. Diagnoses have included lumbar radiculopathy and mechanical low back pain.

Requested Services

Office visits-99212, ultrasound-97035, manual therapy technique-97140, therapeutic exercise-97110, massage therapy-97124 and electrical stimulation-G0283 from 11/8/04-4/1/05.

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

Documents Submitted by Requestor:

1. Request for Reconsideration – 1/10/05, 7/15/05
2. Operative Report – 3/8/05
3. MRI – 10/12/04
4. Neurology and Neurophysiology Center Records – 10/22/04
5. Valley Spine Medical Center Records – 11/8/04-4/1/05

Documents Submitted by Respondent:

1. None submitted

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 member injured his low back on ___ and received both active and passive treatment for his condition from 11/8/04-4/1/05. The MAXIMUS chiropractor reviewer indicated these treatments included office visits, ultrasound, manual therapy, therapeutic exercises, massage therapy and electrical stimulation. The MAXIMUS chiropractor reviewer also noted that according to the North American Spine Society's 2000 clinical guidelines for multidisciplinary spine specialists, the treatments from 11/8/04-11/11/04 fell within the initial phase of care. The MAXIMUS chiropractor reviewer explained that the initial phase of care has clinical indicators of history of acute injury with early positive response to treatment and no urgent surgical indicators. The MAXIMUS chiropractor reviewer indicated that the types of interventions indicated in this phase of treatment include pharmacologic pain control methods, manual therapy techniques, traction, passive modality procedures, injection and therapeutic exercises. The MAXIMUS chiropractor reviewer noted that thus the office visits from 11/8/04-11/11/04 were medically necessary to treat the patient's condition.

The MAXIMUS physician reviewer noted that the records for services from 3/21/05-4/1/05 reported the member received facet block injection to the lumbar spine on 3/8/05. The MAXIMUS physician reviewer indicated that according to the Journal of Musculoskeletal Pain, post injection care should include cold or hot pack application, therapeutic exercises and therapeutic massage. The MAXIMUS physician reviewer also noted that manual therapy, therapeutic exercises and office visits from 3/21/05-4/1/05 were medically necessary to treat this patient's condition. The MAXIMUS chiropractor reviewer also explained that electrical stimulation and ultrasound services from 3/21/05-4/1/05 were not medically necessary to treat the member's condition. (Journal of Musculoskeletal Pain, Dr. Chang-Zern Hong. Vol. 2, Issue 1, 1994. North American Spine Society's 2000 clinical guidelines for multidisciplinary spine specialists.)

Therefore, the MAXIMUS chiropractor reviewer concluded that ultrasound-97035 and electrical stimulation-97035 from 3/21/04-4/1/05 were not medically necessary for treatment of the member's condition. The MAXIMUS chiropractor reviewer also concluded that office visits-99212, manual therapy technique-97140, therapeutic exercise-97110, massage therapy-97124 from 11/8/04-4/1/05 were medically necessary for treatment of this patient's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department