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: Jack P. Mitchell, D.C. P.O. Box 9159 Longview, TX 75608-9159	MDR Tracking No.: M5-06-0519-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: TX Mutual Insurance Company, Box 54	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, "This patient should be afforded the opportunity to continue with his current choice of care. Care that it is proven to benefit the patient and provide him relief and not care that could cause him further disability and hardship."

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 by Jack P. Mitchell, D.C. 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)
3-2-05 – 8-1-05	CPT code 97012 ($17.76 X 9 DOS)	☒ Yes ☐ No	$159.84
3-2-05 – 8-1-05	CPT code 98941 ($43.00 X 11 DOS)	☒ Yes ☐ No	$473.00
3-2-05 – 8-1-05	CPT code G0283 ($13.61 X 6 DOS)	☒ Yes ☐ No	$81.66
GRAND TOTAL			$714.50

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 $714.50.

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 $714.50. 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	1-12-06
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 11, 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 #: M5-06-0519-01
DWC #:
Injured Employee:
Requestor: Jack P. Mitchell, DC
Respondent: Texas Mutual Ins.
MAXIMUS Case #: TW05-0238

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 a 64-year old male who sustained a work related injury on ___. The patient reported that while working as a merchandizing vendor, he injured his low back while attempting to catch and retain a refrigerator from falling. Evaluation and treatment have included MRI, x-rays, medications and chiropractic treatments. Diagnoses have included lumbar disc and facet syndrome and lumbar segmental dysfunction.

Requested Services

Mechanical traction 97012, chiropractic manipulations 98941 and electrical stimulation G0283 from 3/2/05 to 8/1/05.

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

Documents Submitted by Requestor:

1. Letters to IRO Doctor – 6/20/05, 12/10/05
2. Medical Dispute Resolution Findings and Decision – 7/26/05
3. Notice of Independent Review Determination – 7/12/05
4. Request for Reconsideration – 9/29/05

5. Report of Medical Evaluation – 12/21/05
6. Academy Rehab Records – 12/6/04
7. Orthopedic Surgery Notes – 8/5/04
8. Diagnostic Study Reports (e.g., MRIs, x-rays) – 7/28/04
9. Doctor's Daily SOAP Notes & Symptom Drawing and Productivity Index – 3/2/05-10/26/05

Documents Submitted by Respondent:

1. None submitted

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 according to the medical records, the patient was injured on ___ and he received both passive and active treatment to his low back. The MAXIMUS chiropractor consultant noted that during the period of 3/2/05-8/1/05, the patient received mechanical traction, chiropractic manipulations, and electrical stimulation. The MAXIMUS chiropractor consultant also noted that according to the North American Spine Society's Phase II Clinical Guidelines for Multidisciplinary Spine Care Specialists, the patient was in the palliative phase of care during the dates in question. The MAXIMUS chiropractor consultant explained that according to the guidelines, the palliative phase of care includes maintenance procedures that limit severity of recurrent episodes of pain/disability. The MAXIMUS chiropractor consultant indicated the clinical indicators include documented history of persistent failure to respond to prior treatment that surpasses a medical endpoint. The MAXIMUS chiropractor consultant also indicated that the types of interventions include limited passive modalities such as manipulations, a trial or refresher course of secondary or tertiary phase of care, and reinstruction in stretching and thermal modalities for self-care. The MAXIMUS chiropractor consultant noted that the patient's records show he had episodes of aggravation and exacerbations of his low back injury that required return to his treating doctor. The MAXIMUS chiropractor consultant explained that the treating doctor treated him with mechanical traction, electrical stimulation, and manipulation to the lumbar spine. The MAXIMUS chiropractor consultant indicated that due to the patient meeting the clinical indicators and description of a patient in the palliative phase of care, these treatments were medically necessary. (Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialist. North American Spine Society, 2000)

Therefore, the MAXIMUS physician reviewer concluded that the mechanical traction 97012, chiropractic manipulations 98941 and electrical stimulation G0283 from 3/2/05 to 8/1/05 were medically necessary to treat this patient's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department