



Texas Department of Insurance, Division of Workers' Compensation
Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestors Name and Address: SCD Back and Joint Clinic, Ltd. 200 E. 24 th Street, Suite B Bryan, Texas 77803	MDR Tracking No.: M5-06-0859-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance, Box 28	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 includes a description of unpaid services and the reasons why they should be reimbursed.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. The response of May 6, 2005 states that the "Injury did not arise out of or in the course and scope of employment, therefore the carrier denies the claimant has a work-related injury." However, at a BRC held on 8-29-05, carrier representative, Tally Pugh, confirmed that the denial should have been for medical necessity, not compensability, and approved continued care.

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)
11-5-04 – 7-5-05	HCPCS code E1399 (DOP X 1 DOS) See below	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	DOP
11-5-04 – 7-5-05	CPT code 98940 (\$30.13 X 6 DOS + (\$29.80 X 8 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$419.18
11-5-04 – 7-5-05	CPT code 98943 (DOP X 12 DOS) See below	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	DOP
11-5-04 – 7-5-05	CPT code 99211, 99211-25 (\$23.35 X 6 DOS + \$23.48 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$492.30
11-5-04 – 7-5-05	CPT code 99212, 99212-25 (\$41.91 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$209.55
11-5-04 – 7-5-05	CPT code 99213, 99213-25 (\$58.99 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$117.98
11-5-04 – 7-5-05	CPT code 97124 (\$25.69 X 3 DOS + \$25.30 X 10 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$330.07

11-5-04 – 7-5-05	CPT code 97750, 97750-FC (\$33.40 X 28 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$935.20
11-5-04 – 7-5-05	CPT code 97012 (\$17.20 X 8 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$137.60
11-5-04 – 7-5-05	CPT code 97150 (\$21.37 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$85.48
11-5-04 – 7-5-05	HCPCS code A9150 (\$8.00 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$16.00
11-5-04 – 7-5-05	CPT code G0283 (\$13.41 X 5 DOS + \$12.94 X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$183.51
11-5-04 – 7-5-05	CPT code 97530 (\$34.30 X 6 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$205.80
11-5-04 – 7-5-05	CPT code 97112 (\$34.30 X 7 units + \$35.21 X 5 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$416.15
11-5-04 – 7-5-05	CPT code 97110 (\$32.50 X 11 units + \$33.56 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$424.62
11-5-04 – 7-5-05	CPT code 99080 – medical records	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$88.50
11-5-04 – 7-5-05	CPT code 99080-73 (\$15.00 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$30.00
11-5-04 – 7-5-05	DOP code CPT code 97039 (cold laser) (\$14.15 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$70.75
			\$4,162.69 + DOP amounts

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.

Subsection 134.202 (c) (6) of the 2002 MFG states, "for products and services for which CMS or the Division does not establish a relative value unit and/or a payment amount, the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published (DWC) medical dispute decisions, and values assigned for services involving similar work and resource commitments." Therefore, the MAR for HCPCS code E1399 and CPT codes 97039 and 98943 is the amount assigned by the carrier that is consistent with the requirements of this rule.

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 \$4,162.69 plus DOP amounts.

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 1-13-06 the Medical Review Division 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.

CPT code 98943 on 12-17-04, 12-27-04, 1-7-05, and 1-10-05 was denied as "B291-This is a non-covered or bundled procedure according to Medicare." Per the 2002 MFG this service is not global to any other service reported on this date. Recommend reimbursement of 4 DOS X DOP amount as described above.

Regarding CPT code 98943 on 1-3-05, 1-12-05, 1-17-05: This service was reported with CPT code 99212-25 or 99211-25. Per the 2002 MFG description of this code, "Evaluation and management services should not be reported separately unless the patient's condition requires a separately identifiable E/M service beyond the usual pre- and post-service work normally associated with the procedure." The requestor used a modifier to show that the E/M service was a separately identifiable service. Recommend reimbursement of 3 DOS X DOP amount as described above.

CPT code 97750 on 1-20-05 was denied as "B290-The modifier billed is not valid for this date of service." However, the CMS 1500 did not contain the MT (or any) modifier. This service is a Physical Performance Test. The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$133.60.

CPT code 99455-VR on 5-23-05 was denied for medical necessity. According to Rule 134.202 (6)(F) the treating doctor shall bill the medical disability examination with modifier "VR" to indicate a review of the report only, and shall be reimbursed \$50.00. A referral will be made to Compliance and Practices for this violation of the rules. Recommend reimbursement of \$50.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202 (b), 134.202(c)(1) and 134.202 (6)(F).

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 hereby ORDERS the insurance carrier to remit the amount of \$4,212.69 plus DOP amounts 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:

2-21-06

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.

February 3, 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 #: M5-06-0859-01
DWC #: ____
Injured Employee: ____
Requestor: SCD Back and Joint Clinic, Ltd.
Respondent: Liberty Mutual Fire Insurance
MAXIMUS Case #: TW06-0007

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, which 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 had a work related injury on _____. The patient reported that while working as a cutter, she lost her footing while standing on steel grating. Diagnoses included low back pain, cervicalgia, bilateral shoulder pain, left knee pain, bulging cervical disc, degenerative joint disease, internal derangement of left knee and left shoulder strain. Evaluation and treatment have included MRIs, chiropractic services, physical therapy and group/individual therapy.

Requested Services

DME (E1399), chiropractic manipulative treatment (98940/98943), office visits (99211/99211-25/99212/99212-25/99213-25), massage therapy (97124), physical performance test (97750), mechanical traction therapy (97012), therapeutic procedures (97150), Biofreeze patches (A9150), electrical stimulation (G0283), therapeutic activities (97530), neuromuscular re-education (97112), therapeutic exercises (97110), copies/records (99080), special reports (99080-73/work status), unlisted modality (97039) and functional capacity exam (97750-FC) from 11/5/04-7/5/05.

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

Documents Submitted by Requestor:

1. Requestor's Position Statement – 11/30/05
2. Chiropractic Records – 11/5/04-10/4/05
3. Shanti Pain & Wellness Clinic Records – 4/25/05-10/11/05
4. Muscle Strength Testing Reports – 12/1/04-1/14/05
5. Special Testing (Critical Job Demand Testing) Reports – 12/1/04, 12/31/04
6. Prescriptions (Biofreeze, therapeutic ice pack, positioning wedge, knee support, external analgesic) – 11/5/04-5/31/05
7. Diagnostic Study Reports (i.e., MRI) – 12/6/04, 2/2/05, 2/4/05, 3/30/05
8. Orthopedic Records – 4/11/05
9. Designated Doctor Evaluations – 2/17/05, 5/4/05
10. Functional Capacity Evaluation – 5/11/05

Documents Submitted by Respondent:

1. Chiropractic Modality Reviews – 4/16/04, 3/24/05
2. Chiropractic Records – 12/31/04-2/24/05

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 this patient suffered a multi-level and multi-area injury that creates greater complexity in managing treatment. The MAXIMUS chiropractor consultant noted she was treated with various types of therapy, manipulations, DME, injections and medications. The MAXIMUS chiropractor consultant also that all these modalities worked initially but she was not able to sustain her regular work duties for an extended period of time. The MAXIMUS chiropractor consultant explained a work conditioning program was established, but took months to get started. The MAXIMUS chiropractor consultant indicated there is an overwhelming amount of supporting documentation for the prescribed treatment. The MAXIMUS chiropractor consultant also indicated there were designated doctor evaluations that found the

member not to be at maximal medical improvement (MMI) and suggested further treatment that fell within the guidelines of treatment already being provided. The MAXIMUS chiropractor consultant noted that due to the multiple level body part injuries, her condition required a more diverse treatment than a one-level injury. The MAXIMUS chiropractor consultant indicated the treating provider appropriately referred the patient to other practitioners to assist in bring resolution to her care. The MAXIMUS chiropractor consultant noted that that the type of treatment and amount of care given to this patient from 11/5/04-7/5/05 was within accepted standards of care for treatment of this complex injury.

Therefore, the MAXIMUS chiropractor consultant concluded that DME (E1399), chiropractic manipulative treatment (98940/98943), office visits (99211/99211-25/99212/99212-25/99213-25), massage therapy (97124), physical performance test (97750), mechanical traction therapy (97012), therapeutic procedures (97150), Biofreeze patches (A9150), electrical stimulation (G0283), therapeutic activities (97530), neuromuscular re-education (97112), therapeutic exercises (97110), copies/records (99080), special reports (99080-73/work status), unlisted modality (97039) and functional capacity exam (97750-FC) from 11/5/04-7/5/05 were supported as medically necessary services for treatment of the patient's conditon.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department