



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:

Dr. Suhail Al-Sahli
1210A Nasa Rd. 1
Houston, Texas 77058

MDR Tracking
No.:

M5-06-0964-01

Claim No.:

Injured
Employee's
Name:

Respondent's Name and Address:

Ace American Insurance Company, Box 15

Date of Injury:

Employer's
Name:

Insurance
Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Necessary Medical Treatment."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Peer review of January 17, 2005 found ongoing chiropractic treatment was no longer medically reasonable and necessary."

Principle Documentation:

1. Peer review
2. EOB's

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)
1-24-05 – 4-13-05	97110 (49 units @ \$35.86)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,757.14
1-24-05 – 4-13-05	99212 (6 DOS @ \$46.41<MAR)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$278.46
1-24-05 – 4-13-05	99213 (17 DOS @ \$65.21<MAR)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,108.57
1-24-05 – 4-13-05	98940-25 (14 units @ \$32.84<MAR)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$459.76
1-24-05 – 4-13-05	98941-25 (3 units @ \$45.60<MAR)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$136.80
1-24-05 – 4-13-05	97124 (17 units @ \$28.14<MAR)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$478.38
1-24-05 – 4-29-05	97112, 97116	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
4-14-05 – 4-29-05	97110, 99212, 99213, 98940-25, 98941-25, 97124, 97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
Total Due			\$4,219.11

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 \$4,219.11.

"25" is not an appropriate modifier for CPT code 98940 per Rule 134.202(b). The Requestor did not bill with the "73" modifier on CPT code 99080.

Regarding CPT code 99080 on 2-1-05: The carrier denied CPT Code 99080-73 with a "V" for unnecessary medical treatment based on a peer review; however, the DWC-73 is a required report per Rule 129.5. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$15.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5
28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202(c)(1)
Texas Labor Code 413.031

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 \$4,234.11. The Division hereby **ORDERS** the Respondent 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:

Medical Dispute
Officer

8-10-06

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.

July 7, 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 #: M5-06-0964-01
DWC #: _____
Injured Employee: _____
Requestor: Suhail Al-Sahli, DC
Respondent: Ace American Insurance
MAXIMUS Case #: TW06-0095

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 chiropractor on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has 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 chiropractic provider has 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 chiropractic reviewer 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 had a work related injury on _____. Records indicate that the member sustained a mechanical injury to the low back while putting away produce when he lifted a box. Diagnoses included discogenic pain, lumbar radiculopathy, axial pain, myofascial pain syndrome, right lumbar facet arthropathy, right sacroiliitis, post lumbar laminectomy, lumbar/sacral radicuopathy, and spondylolisthesis. Evaluation and treatment has included chiropractic services, surgery, pain medications, and facet injections.

Requested Services

Therapeutic exercises (97110), office visits (99212), neuromuscular re-education (97112) chiropractic manipulation (98940-25), massage (97124), and gait training (97116) from 1/24/05-4/29/05.

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

Documents Submitted by Requestor:

1. Records and Correspondence from Suhail S. Al-Sahli, DC – 1/24/05-6/12/06
2. Determination Notices – 11/5/04-11/1/05
3. Physician Advisory Review – 2/15/06
4. Records from Rezik A. Saqer, MD – 1/28/05-12/6/05
5. Houston Spine and Neurosurgery Center Records – 10/22/04-3/4/05
6. Clear Lake Regional Medical Center Records – 7/14/04
7. Diagnostic Studies (e.g., MRI) – 10/13/03
8. Records from Sunil A. Vachhani, DC – 1/13/04

Documents Submitted by Respondent:

1. Physician Advisory Review – 1/17/05,
2. Designated Doctor Evaluation – 2/17/05

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 consultant indicated the patient was injured on ___ and underwent conservative treatment to the spine and then surgery. The MAXIMUS chiropractor consultant noted the surgical procedure included fusion at L5-S1, bilateral L4 laminectomy, and reduction of spondylolisthesis. The MAXIMUS chiropractor consultant also noted the patient was treated with injections to the lumbar spine prior to 1/24/05. The MAXIMUS chiropractor consultant explained that according to the Journal of Musculoskeletal Pain, post injection therapy should include cold and hot pack application, therapeutic exercises, mobilization, and massage. The MAXIMUS chiropractor consultant noted that the neuromuscular re-education provided to the patient did not meet post injection therapy criteria and therefore was not medically necessary.

The MAXIMUS chiropractor consultant indicated the medical records state that the patient had a surgical procedure on 2/20/05 to remove a bone growth stimulator. The MAXIMUS chiropractor consultant noted that according to the 2005 Official Disability Guidelines, post surgical treatment

to the spine allows for up to 16 visits in 8 weeks. The MAXIMUS chiropractor consultant explained neuromuscular re-education and gait training are performed when there are postural, balance, or proprioception deficits that this patient did not have. The MAXIMUS chiropractor consultant indicated that services provided to the patient from 4/14/05-4/29/05 fall outside of the previously stated guidelines for post-operative rehabilitation and therefore are not deemed medically necessary for treatment of the patient's condition. (Official Disability Guidelines Work Loss Data, 2005. Journal of Musculoskeletal Pain; 2(1), 1994.)

Therefore, the MAXIMUS chiropractic consultant concluded that therapeutic exercises (97110), office visits (99212), chiropractic manipulation (98940-25), and massage (97124) from 1/24/05-4/13/05 were medically necessary for treatment of the member's condition.

The MAXIMUS chiropractic consultant also concluded that therapeutic exercises (97110), office visits (99212), chiropractic manipulation (98940-25), and massage (97124) from 4/14/05-4/29/05 were not medically necessary for treatment of the member's condition. The MAXIMUS chiropractic consultant concluded that neuromuscular re-education (97112) and gait training (97116) from 1/24/05-4/29/05 were not medically necessary for treatment of the member'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