



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.: M5-06-0984-01
New Help Clinics, P.A. 5601 Bridge Street Ste. 550 Ft. Worth, TX 76112	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Federal Insurance Company, Box 17	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, "The 3 level lumbar spinal fusion has complicated the case. The injured worker's treatment has provided physical and functional benefits in order to assist with dealing with symptomatology and increasing activities of daily living."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "The Requestor should not be entitled to any reimbursement for the disputed treatments or services as they failed to provide any documentation to support the medical necessity of the medications."

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)
1-25-05 - 3-4-05	CPT code 97124 (\$27.33 X 17 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$464.61
1-25-05 - 3-4-05	CPT code 97112 (\$35.66 X 17 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$606.22
1-25-05 - 3-4-05	CPT code 99211 (\$26.25 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$131.25
1-25-05 - 3-4-05	CPT code 99213 (\$65.18 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$195.54
1-25-05 - 3-4-05	CPT code 99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$102.69
1-25-05 - 3-4-05	CPT code 99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
1-25-05 - 3-4-05	CPT code 97140 (\$28.00 X 17 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$476.00
1-25-05 - 3-4-05	CPT code 97150 (\$21.69 X 17 DOS-report once per visit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$368.73
1-25-05 - 3-4-05	CPT code 97150 (more than one unit per visit)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
3-5-05 - 8-15-05	CPT codes 97124, 97112, 99211, 99213, 99214, 99080-73, 97140, 97150	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Total		\$2,360.04

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. The amount due the requestor for the items denied for medical necessity is \$2,360.04.

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 2-22-06 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 97140-59 on 3-4-05 was denied by the carrier as "W4-No additional payment allowed after review." This code is considered by Medicare to be a component procedure of CPT code 95831 which was billed on this date. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. A modifier was used appropriately to differentiate the services. Recommend reimbursement per Rule 134.202(c)(1) of \$28.00.

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 requestor is not entitled to a refund of the IRO fee. The Division has determined that the requestor is entitled to reimbursement in the amount of \$2,388.04. 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

5-1-06

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.

April 28, 2006
April 25, 2006
April 13, 2006

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 #: M5-06-0984-01

DWC #:

Injured Employee:

Requestor: New Help Clinic

Respondent: Federal Insurance Company

MAXIMUS Case #: TW06-0028

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 sustained a work related injury on _____. It is not clear from the available case file documentation how the injury occurred. Diagnoses included low back pain, radiculopathy, and internal disc derangement. Evaluation and treatment have included chiropractic treatment, surgery, CT scans, MRIs, injections, and medications.

Requested Services

97140-manual therapy tech, 97124-massage, 97150-therapeutic procedures, 97112-neuromuscular reeducation, 99211, 99213, 99214-office visit, 99080-73-work status report from 1/25/05-8/15/05.

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

Documents Submitted by Requestor:

1. New Help Clinic's PA Records and Correspondence – 1/25/05-8/15/05
2. Table of Disputed Services – 1/25/05-8/15/05
3. Request for Reconsideration – 5/6/05, 6/21/05, 7/19/05

4. Procedure Note – 6/7/04, 9/10/04
5. Orthopedic Records – 4/6/04-2/3/05
6. Diagnostic Studies (e.g., MRI, CT scan, etc) - 4/18/02, 4/26/02, 6/7/04

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 consultant indicated the patient started with non-active based physical therapy until 12/27/04 and then started active therapy. The MAXIMUS chiropractor consultant noted that 3 treatments per week for 10 weeks should be allowed due to the complex nature of his care. The MAXIMUS chiropractor consultant also noted that had he made better progress, more care would have been indicated. The MAXIMUS chiropractor consultant explained that he did have a slight decrease in his pain level and a slight increase in range of motion, however, not enough to warrant further care. The MAXIMUS chiropractor consultant indicated the need for 45 minutes of supervised therapy is not supported and only 15 minutes of supervised therapy was necessary. The MAXIMUS chiropractor consultant noted that manual therapy techniques are contraindicated for at least 6 months following a newly performed 3 level lumbar fusion. The MAXIMUS chiropractor consultant indicated that trying to mobilize a segment that has just been fused is not medically necessary. The MAXIMUS chiropractor consultant noted that the chances of this patient recovering are unlikely and doing more of the same interventions without significant improvement is not supported. The MAXIMUS chiropractor consultant also noted that he is allowed 10 weeks instead of 4-6 weeks of therapy due to the complex nature of his injury and previous surgeries.

Therefore, the MAXIMUS chiropractor consultant concluded that 97124-massage, 97112-neuromuscular reeducation, 99211, 99213, 99214-office visit, 99080-73-work status report, and 97140-manual therapy tech, and 97150-therapeutic procedures from 1/25/05-3/4/05 were medically necessary for treatment of the member's condition.

The MAXIMUS chiropractor consultant concluded that 97140-manual therapy tech, 97124-massage, 97150-therapeutic procedures, 97112-neuromuscular reeducation, 99211, 99213, 99214-office visit, 99080-73-work status report from 3/5/05-8/15/05 were not medically necessary for treatment of the patient's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department