



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.: M5-06-1044-01
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:
TX Mutual Insurance Company, Box 54	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 care rendered to the patient has met criteria set by Texas Labor Code section 408.21."

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 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)
5-23-05 – 6-20-05	CPT code 97035 (\$15.59 X 8 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$124.72
5-23-05 – 6-20-05	CPT code G0283 (none billed during this time period)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
5-23-05 – 6-20-05	CPT code 97110 (\$36.00 X 29 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,044.00
5-23-05 – 6-20-05	CPT code 97140 (\$34.16 X 18 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$614.88
5-26-05 – 6-15-05	CPT code 99212 (\$50.00 X 8 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$400.00
6-20-05	CPT code 99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$105.00
6-21-05 – 9-22-05	CPT codes 97035, G0283, 97110, 97140, 99212, 99214	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
Total			\$2,288.60

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 \$2,288.60.

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 3-2-06 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 on 6-13-05, 6-15-05, 6-17-05, 6-20-05 and 7-22-05 was denied by the carrier as "97-Payment is included in the allowance for another service/procedure" and/or as "434-The value of this procedure is included in the value of the mutually exclusive procedure." According to the 2002 MFG this procedure is considered by Medicare to be a mutually exclusive procedure of 97012 which was billed on these dates of service. No modifier was used to differentiate the services. Recommend no reimbursement.

CPT code 97110 on 6-13-05, 6-17-05, 6-20-05 and 6-23-05 was denied by the carrier as "97-Payment is included in the allowance for another service/procedure" and/or as "434-The value of this procedure is included in the value of the mutually exclusive procedure." According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of 97113 which was billed on these dates of service. No modifier was used to differentiate the services. Recommend no reimbursement.

CPT code 99080-73 on 9-22-05 was denied by the carrier as "248-TWCC 73 not properly completed or submitted in excess of the filing requirements." The requestor provided documentation to support proper documentation per Rule 129.5. Reimbursement of \$15.00 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5, 133.307(g)(3)(A-F), 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 Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$2,303.60. 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:

Authorized Signature

Donna Auby

Typed Name

4-27-06

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 13, 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 #: M5-06-1044-01

DWC #:

Injured Employee:

Requestor: Valley Spine Medical Center

Respondent: Texas Mutual Insurance Company

MAXIMUS Case #: TW06-0045

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 _____. The patient reported that while carrying/lifting a section of metal pipe, he felt a sharp stabbing pain in his low back while bending at the waist. He has been diagnosed with lumbago, lumbar sprain/strain, and muscle spasms. This patient has been treated with chiropractic treatment and over the counter medications.

Requested Services

97140-Manual therapy technique, 97110-Therapeutic exercises, 99212, 99213, 99214-Office visit, 97035-ultrasound, G0283-electrical stimulation from 5/23/05-9/22/05.

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

Documents Submitted by Requestor:

1. Summary of Health Care Provider's Position – 8/31/05
2. Request for Reconsideration – 11/2/05, 12/1/05
3. Diagnostic Studies (e.g., MRI, etc.) – 6/14/05
4. Valley Spine Medical Center Records and Correspondence – 5/20/05-9/22/05

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 consultant indicated that 97140 is documented as joint mobilization and myofascial release and are considered 2 separate forms of care. The MAXIMUS chiropractor consultant noted that the need for more than 4 units of supervised care is not substantiated. The MAXIMUS chiropractor consultant also noted the use of ultrasound and electrical stimulation is used in the acute phase of care to promote healing. The MAXIMUS chiropractor consultant explained that the patient had a lumbar spine injury and an L5-S1 herniated lumbar disc was found on 6/14/05. The MAXIMUS chiropractor consultant indicated that patient has not radicular symptoms and the herniated lumbar disc did not seem to be the source of his pain. The MAXIMUS chiropractor consultant noted that in the absence of physical findings (exam) there is minimal objective evidence to justify care past 4 weeks if there is no subjective or objective improvement. The MAXIMUS chiropractor consultant indicated every office visit from 6/2/05-9/22/05 has the same moderate constant pain level with one exception. The MAXIMUS chiropractor consultant explained there are no pain scales or diagrams by the patient documenting progress, or lack thereof. The MAXIMUS chiropractor consultant noted that the examinations do not substantiate improvement or a change of plan to try new treatments. The MAXIMUS chiropractor consultant also noted that the guidelines allow 4 weeks of treatment without documented improvement to justify further services.

Therefore, the MAXIMUS chiropractor consultant concluded that 97035-ultrasound and G0283-electrical stimulation from 5/23/05-6/20/05, 99212-office visit from 5/26/05-6/15/05, 99214-office visit on 6/20/05, 97110-Therapeutic exercises from 5/23/05-6/20/05 and 97140-Manual therapy technique from 5/23/05-6/20/05 were medically necessary for treatment of the member's condition. The MAXIMUS chiropractor consultant concluded that the services 97140-Manual therapy technique, 97110-Therapeutic exercises, 99212, 99213, 99214-Office visit, 97035-ultrasound, G0283-electrical stimulation from 6/21/05-9/22/05 were not medically necessary for treatment of the patient's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department