



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: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Valley Spine Medical Center 5327 South McColl Rd. Edinburg, Texas 78539	MDR Tracking No.: M5-06-1075-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company, Box 19	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, "Treatment was medically necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 response. Position Summary states, "Enclosed please find documents responsive to this issue for your review."

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)
4-27-05 – 5-11-05	CPT code 99215	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$142.75
4-27-05 – 5-11-05	CPT code 97110 (\$33.56 X 56 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,879.36
4-27-05 – 5-11-05	CPT code G0283 (\$13.61 X 7 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$95.27
4-27-05 – 5-11-05	CPT code 97012 (\$17.76 X 7 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$124.35
4-27-05 – 5-11-05	CPT code 99212 (\$45.26 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$226.30
5-12-05 – 7-15-05	CPT codes 99215(not billed for these dates of service), 99212, 99212-25, 97110, G0283, 97012, 97140, 97035, 97113	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Total		\$2,468.03

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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

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 \$2,468.03. 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 by:

Donna Auby

4-24-06

Authorized Signature

Typed Name

Date of Findings and Decision

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 #: M5-06-1075-01
DWC #:
Injured Employee:
Requestor: Valley Spine Medical Center
Respondent: American Home Assurance c/o ARCFI
MAXIMUS Case #: TW06-0043

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 female who sustained a work related injury on _____. The patient reported that while lifting a 25" television set box from a cart, she felt and heard a small pop in the low back area when bent over at the waist and twisting.

She has been diagnosed with lumbosacral radiculopathy, lumbar sprain/strain, and muscle spasms. This patient has been treated with chiropractic treatment, individual therapy, EMG/NCS, and physical therapy techniques.

Requested Services

Office visits 99215, 99212, 99212-25; therapeutic exercises 97110, electrical stimulation G0283, mechanical traction 97012, manual therapy technique 97140, ultrasound 97035, and aquatic therapy 97113 from 4/27/05 to 7/15/05.

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

Documents Submitted by Requestor:

1. Valley Spine Medical Center Records and Correspondence – 3/28/05-7/15/05
2. Neurosurgeon Evaluation – 4/29/05
3. Open MRI of McAllen Records – 4/1/05

Documents Submitted by Respondent:

1. Case Summary – 3/16/06
2. Valley Spine Medical Center Records and Correspondence – 3/28/05-12/1/05
3. Determination Notices – 5/26/05, 5/31/05, 6/29/05, 7/12/05, 7/29/05, 8/25/05, 10/18/05, 12/26/05, 1/6/06
4. Employer's First Report of Injury – 3/17/05
5. Chronic Pain Institute Records and Correspondence – 5/10/05-6/29/05
6. Neurology Records and Correspondence – 6/23/05
7. Ortho Sports Records – 6/23/05
8. Open MRI of McAllen Records – 4/1/05
9. Neurosurgeon Evaluation – 4/29/05

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 had a herniated L4-5 disc and consecutive care was warranted for 4-6 weeks to see if treatment interventions were producing lasting benefit and relieving pain. The MAXIMUS chiropractor consultant noted there was no evidence of subjective or objective improvement after 6 weeks of treatment. The MAXIMUS chiropractor consultant also noted that there was no evidence to indicate the patient was referred to another type of doctor at this point in her care. The MAXIMUS chiropractor consultant explained there was no change in the treatment plan except to follow-up after electrical stimulation. The MAXIMUS chiropractor consultant indicated there is little, if any peer reviewed findings that show that care was beneficial following electrical stimulation. The MAXIMUS chiropractor consultant noted that continued use of passive modalities past 6 weeks is not supported without documented improvement. The MAXIMUS chiropractor consultant indicated there was no reason that the patient was unable to perform therapeutic exercises at home. The MAXIMUS chiropractor consultant noted there was no evidence regarding the need for 2 hours of supervised therapy past 6 weeks and training for home based care should start after 2 weeks of slow progress. The MAXIMUS chiropractor consultant also noted that the normal time for a low back injury is 4 weeks of treatment that is extended to 6 weeks for a herniated disc (Mercy Guidelines). The MAXIMUS chiropractor consultant explained that in the absence of documented continuing significant objective and subjective improvement, medical necessity was not established past 6 weeks of treatment interventions.

Therefore, the MAXIMUS chiropractor consultant concluded that office visits 99215, 99212, 99212-25; therapeutic exercises 97110, electrical stimulation G0283, mechanical traction 97012, manual therapy technique 97140, ultrasound 97035, and aquatic therapy 97113 from 4/27/05 to 5/11/05 were medically necessary for treatment of the member's condition. The MAXIMUS chiropractor consultant concluded that the office visits 99215, 99212, 99212-25; therapeutic exercises 97110, electrical stimulation G0283, mechanical traction 97012, manual therapy technique 97140, ultrasound 97035, and aquatic therapy 97113 services from 5/12/05-7/15/05 were not medically necessary for treatment of the patient's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department