



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:  Carl M. Naehritz III, D. C. 2900 Hwy 121, Suite 120 Bedford, TX 76021	MDR Tracking No.: M5-06-1185-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Liberty Insurance Corp., 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 states, "I respectfully request the Board to find that care was medically necessary and all bills should be paid immediately, as set up in the TDI Rules and Regulations 133.304(D)."

**PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Documents include the DWC 60 response. Position summary states, "Not medically necessary."

**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)
6-15-05 – 10-5-05	HCPCS code E0230 (\$8.48 per the HCPCS DMEPOS Schedule)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$8.48
6-15-05 – 10-5-05	CPT code 99213-59 (See note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
6-15-05 – 10-5-05	CPT code 97530 (\$33.10<MAR X 12 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$397.20
6-15-05 – 10-5-05	CPT code 97140 (\$29.73<MAR X 14 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$416.22
6-15-05 – 10-5-05	CPT code 97110 (\$31.43<MAR X 12 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$377.16
6-15-05 – 10-5-05	CPT code 97750-MT (Withdrawn by requestor)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
6-15-05 – 10-5-05	CPT code 97750-RM (Withdrawn by requestor)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
6-15-05 – 10-5-05	CPT code 98941 (No services in dispute during this time period.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
11-29-05	CPT code 98941	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

9-15-05, 10-24-05	CPT code 99354-21 (See note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
6-15-05 – 10-5-05	CPT code 97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
7-14-05, 7-19-05, 8-2-05, 9-2-05, 9-14-05	CPT code 99354-21	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Total		\$1,199.06

**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.

Note: No reimbursement will be ordered and the requestor will be billed for using invalid modifiers on CPT codes 99354 and 99213 and in accordance with Rule 134.202(b).

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 \$1,199.06. (The value of the services determined by the IRO to be medically necessary was greater than the value of the services which the IRO determined were not medically necessary.)

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.

HCPCS code E1399 on 6-15-05 was denied by the carrier as "B377-This is a bundled procedure." Per the 2002 MFG this service is bundled with other services rendered on this date. No reimbursement recommended.

CPT code 99372 on 7-1-05 was denied by the carrier as "U693-this procedure is incidental to the related primary procedure billed." Per the 2002 MFG this service is bundled with the other services performed on this date. No reimbursement recommended.

CPT code 99071 on 7-11-05 was denied by the carrier as "B377-This is a bundled procedure." Per the 2002 MFG these are educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician. No reimbursement recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.202(b) 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 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 reimbursement in the amount of \$1,199.06. 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, Medical Dispute Officer	5-26-06
_____ 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.**

May 17, 2006

May 8, 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 #: M5-06-1185-01**  
**DWC #: \_\_\_\_\_**  
**Injured Employee: \_\_\_\_\_**  
**Requestor: Carl M Naehritz III, DC**  
**Respondent: Liberty Mutual**  
**MAXIMUS Case #: TW06-0067**

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 while assisting another employee with a jammed belt, a 200 pound object fell on his head. Diagnoses included neck pain, shoulder pain, headache, facial pain, nose pain, and myofascitis. Evaluation and treatment has included chiropractic services, CT scans, x-rays, EMG, nerve conduction velocity testing,

## Requested Services

Ice cap/collar E0230, prolonged physician service 99354-21, office visit 99213-59, therapeutic activities 97530, manual therapy technique 97140, therapeutic exercises 97110, neuromuscular re-education 97112, muscle testing 97750-MT, range of motion testing 97750-RM and chiropractic manipulation 98941 from 6/15/05-11/29/05.

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

### *Documents Submitted by Requestor:*

1. Request for Appeal – 4/19/06
2. Chiropractic Records and Correspondence – 6/15/05-12/28/05
3. Authorization for Absence – 6/15/05-8/1/05
4. Return to Work or School Forms – 9/16/05, 11/30/05
5. Prescriptions and Orders – 6/15/05-9/16/05
6. Letter of Medical Necessity – 8/30/05
7. Neurology Records and Correspondence – 9/7/05-9/14/05
8. Concurrent Review(s) – 7/29/05

### *Documents Submitted by Respondent:*

1. Concurrent Review(s) – 7/29/05
2. Orthopedic Records and Correspondence – 9/8/05
3. Chiropractic Records and Correspondence – 6/15/05-12/28/05
4. Baylor Regional Medical Center Records – 6/15/05
5. Neurology Records and Correspondence – 9/7/05-9/14/05
6. Diagnostic Studies (e.g., EMG, nerve conduction velocity, MRI) – 6/28/05, 7/14/05, 9/14/05

## 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 began treatment on 6/15/05. The MAXIMUS chiropractor consultant explained that according to the North American Spine Society's Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists, 2003, treatment in the initial and secondary phases of care can last up to 16 weeks. The MAXIMUS chiropractor consultant noted that using the previously stated treatment guidelines, the office visits, muscle testing, range of motion testing, ice collar, and manipulations from 6/15/05-10/5/05 would fall within the accepted treatment range and were medically necessary to treat this patient. The MAXIMUS chiropractor consultant noted that according to the American Physical Therapy Association, neuromuscular reeducation therapy is used to improve balance, coordination, kinesthetic sense, posture, and proprioception. The MAXIMUS chiropractor consultant indicated the medical records provided for review did not show the patient to have any of these symptoms during the time of injury. The MAXIMUS chiropractor consultant explained that without the patient having the need to improve any of the previously stated symptoms, there is no medical necessity for this treatment. The MAXIMUS chiropractor consultant indicated the medical records revealed that there was documentation of prolonged physician services in face to face review of doctors reports with the patient on 9/15/05 and 10/24/05, but no documentation to support the other dates of service (7/14/05, 7/19/05, 8/2/05, 9/2/05, and 9/14/05). (North American Spine Society's Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists, 2003.)

Therefore, the MAXIMUS chiropractor consultant concluded that the ice cap/collar E0230, office visit 99213-59, therapeutic activities 97530, manual therapy technique 97140, therapeutic exercises 97110, muscle testing 97750-MT, range of motion testing 97750-RM and chiropractic manipulation 98941 from 6/15/05-10/5/05 and prolonged physician service 99354-21 on 9/15/05 and 10/24/05 were medically necessary for treatment of the member's condition.

The MAXIMUS chiropractor consultant also concluded that neuromuscular re-education 97112 from 6/15/05-11/29/05, chiropractic manipulation 98941 on 11/29/05, prolonged physician service 99354-21 on 7/14/05, 7/19/05, 8/2/05, 9/2/05, and 9/14/05 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