



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:

Allen Glen Haywood, D.C.
P.O. Box 242
Mabank, TX 75147

MDR Tracking No.: M5-06-1274-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

TX Mutual Insurance Company, Box 54

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, "The injured worker is entitled to healthcare as and when needed that specifically promotes recovery."

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)
3-17-05 – 4-25-05	CPT code 98940 (\$31.36 X 13 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$407.68
3-17-05 – 4-25-05	CPT code 97012 (\$17.76 X 13 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$230.88
3-17-05 – 4-25-05	CPT code G0283 (\$67.12 X 13 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$872.56
3-17-05 – 4-25-05	CPT code 97110 (\$33.56 X 29 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$33.56
3-17-05 – 12-14-05	CPT code 99080-73 (\$15.00 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$45.00

3-17-05 – 12-14-05	CPT code 99212-25 (\$45.00< MAR X 1 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$45.00
3-17-05 – 4-25-05	CPT code 97150 (none in dispute during this time period)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
4-25-05 – 12-14-05	CPT code 98940, 97012, G0283, 97110, 97150	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Grand Total		\$1634.68

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 \$1634.68.

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 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 \$1634.68. 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

5-17-06

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 8, 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 #: M5-06-1274-01
DWC #: _____
Injured Employee: _____
Requestor: Allen Glen Haywood, DC
Respondent: Texas Mutual Insurance Company
MAXIMUS Case #: TW06-0066

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 the patient was in a crane bucket, it malfunctioned pinning him against a wall. Diagnoses included cervical strain/sprain, brachial neuritis, past cervical disc surgery, shoulder strain/sprain, bilateral carpal tunnel syndrome and elbow pain. Evaluation and treatment included chiropractic services, surgery, physical performance evaluation, MRI, and nerve conduction study.

Requested Services

98940-AT-Chiropractic Manual Treatment, 97012-Mechanical Traction, G0238-Electrical Stimulation, 97110-Therapeutic Exercises, 99080-73-DWC 73 Report, 99212-25-Office Visit, 97150-Therapeutic Procedure from 3/17/05-12/14/05.

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

Documents Submitted by Requestor:

1. Request for Reconsideration – 6/21/05, 11/20/05, 2/20/06
2. Canton Healthcare Systems Records – 9/30/05
3. A-Medical Advantage Healthcare Systems Records – 9/19/05
4. Diagnostic Studies (e.g., electrodiagnostic studies, etc) – 5/18/05
5. Baylor Neurosurgery Records – 3/17/05
6. Chiropractic Records – 1/3/05-12/14/05

Documents Submitted by Respondent:

1. Treatment History – 11/12/04-2/13/06
2. Chiropractic Records – 1/3/05-12/14/05
3. Diagnostic Studies (e.g., electrodiagnostic studies, etc) – 5/18/05
4. MD Rehab of Texas Records – 7/6/05
5. Rehabilitation Medical Specialists of Dallas Report – 7/7/05
6. Physical Medicine & Rehabilitation & Pain Management Consultation – 7/27/05
7. Canton Healthcare Systems Records – 8/19/05

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 surgery to the cervical spine that included a fusion. The MAXIMUS chiropractor consultant explained that according to the North American Spine Society's Phase III clinical guidelines for multidisciplinary spine care specialists, treatment in the initial and secondary phases of care can last up to 16 weeks. The MAXIMUS chiropractor consultant noted that the patient began post-operative rehabilitation on 1/3/05. The MAXIMUS chiropractor consultant noted that the treatments provided from 3/17/05-4/25/05 were within the acceptable timeframe for initial and secondary phases of care. The MAXIMUS chiropractor consultant indicated the tertiary phase of care has interventions that include interdisciplinary programs (such as chronic pain management, functional restoration, and work hardening, work conditioning), injections, and pharmacological pain control. The MAXIMUS chiropractor consultant explained that after 4/25/05, the patient was in the tertiary phase of care and the treatments performed (electrical

stimulation, therapeutic exercise, chiropractic manual treatment, and therapeutic procedures) were not acceptable interventions beyond 16 weeks from the initiation of post-operative rehabilitation. The MAXIMUS chiropractor consultant indicated that the office visits and DWC-73 forms from 4/25/05-12/14/05 were necessary to treat this patient in that the visits were needed to examine and assess the patient's progress with treatment and the forms were necessary to document off-work status, referrals and restrictions. (North American Spine Society Phase III Guidelines for Multidisciplinary Spine Care Specialists, 2003.)

Therefore, the MAXIMUS chiropractor consultant concluded that 98940-AT-Chiropractic Manual Treatment, 97012-Mechanical Traction, G0238-Electrical Stimulation, 97110-Therapeutic Exercises, 99080-73-DWC 73 Report, 99212-25-Office Visit, 97150-Therapeutic Procedure from 3/17/05-4/25/05 and 99212-25-Office Visit and 99080-73-DWC 73 Report from 4/25/05-12/14/05 were medically necessary for treatment of the member's condition. The MAXIMUS chiropractor consultant also concluded that 98940-AT-Chiropractic Manual Treatment, 97012-Mechanical Traction, G0238-Electrical Stimulation, 97110-Therapeutic Exercises, and 97150-Therapeutic Procedure from 4/25/05-12/14/05 were not medically necessary for treatment of the member's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department