



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:** (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:  Dr. Danny Bartel 1722 Ninth Wichita Falls, TX 76301	MDR Tracking No.: M5-06-1696-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Box 45	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.

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

Documents include the DWC 60 response. Position summary states, "The Office will maintain its denial for date of service 7-8-05 for ANSI code 50."

**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)
7-8-05	CPT code 20550 (\$55.36 X 8 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$442.88
7-8-05	HCPCS code S0020 (See note below.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
7-8-05	HCPCS code J3301 (See note below.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$26.00
7-8-05	CPT code 99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
	Total		\$483.88

**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.

Date of service 05-06-05 per Rule 133.308(e)(1) was not timely filed and is ineligible for review.

The Division has reviewed the enclosed IRO decision and determined that the requestor did prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$483.88.

HCPCS code S0020 was found to be necessary by the Independent Reviewer. However, per the 2002 MFG this is not a valid HCPCS code. Recommend no reimbursement.

HCPCS code J3301 was found to be necessary by the Independent Reviewer. Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor when billing for services for which the Division has not established a maximum allowable reimbursement. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has provided evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers.

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

28 Texas Administrative Code Sec Rule 133.304 (i) (1-4), 133.307(g)(3)(D), 133.308 and 134.202(c)(1).  
Texas Labor Code 413.011

**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 (\$650.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to additional reimbursement in the amount of \$483.88. 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:**

Medical Dispute Officer

6-27-06

\_\_\_\_\_  
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.**

June 22, 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 #: M5-06-1696-01**  
**DWC #: \_\_\_\_**  
**Injured Employee: \_\_\_\_**  
**Requestor: Danny Bartel, MD**  
**Respondent:**  
**MAXIMUS Case #: TW06-0094**

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 physician who is board certified in neurology 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 has been approved as an exception to the ADL requirement. A certification was signed that the reviewing 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 physician 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 \_\_\_\_\_. The patient reported that that while unloading brush from a pickup truck he experienced pain. Diagnoses included myofascial syndrome, spondylosis, degenerative facet arthropathy, and degenerative disc disease. Evaluation and treatment have included previous surgeries, MRIs, CT scans, bone scans, physical therapy, medication, and epidural steroid injections.

## Requested Services

Injection tendon sheath/ligament (20550), injection Bupivacaine HCL 30 ml (S0020), injection triamcinolone acetonide per 10 mg (J3301) and special report (99080-73) on 7/8/05.

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

### *Documents Submitted by Requestor:*

1. Neurology Records and Correspondence – 7/1/97-2/6/06
2. Review of Medical Information Report – 9/14/04
3. Hospital Records – 6/17/97-8/3/04
4. Diagnostic Studies (i.e., MRI, CT scan, x-rays, ultrasound, bone scans, EMG, etc.) – 6/15/97-2/21/06
5. Physical Therapy Records – 9/5/97-12/19/00
6. Pain Management Records – 12/13/99-6/12/01
7. Texas Back Institute of Plano – 10/31/00-1/9/01
8. Rehabilitation Records and Correspondence – 6/20/00-6/23/00
9. Orthopedic Surgery Records and Correspondence – 6/16/99

### *Documents Submitted by Respondent:*

1. United Regional Health Care System – 8/23/00
2. Pain Management Records – 4/21/01-9/18/01
3. Parker Road Surgery Center Records – 5/30/01
4. Neurology Records and Correspondence – 8/6/01-7/8/05
5. Presbyterian Hospital of Plano Records - 8/6/01-9/11/01
6. Diagnostic Studies (i.e., MRI) – 1/15/03, 3/4/04
7. Review of Medical Information Report – 9/14/04

## Decision

The Carrier's denial of authorization for the requested services is 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 physician consultant indicated the patient underwent a past lumbar spinal fusion procedure. The MAXIMUS physician consultant noted he also had treatment with multiple types of injections (i.e., epidural steroid, selective nerve root, facet blocks, and sciatic blocks). The MAXIMUS physician consultant explained that as of 2004 the injections seemed to be helping to improve his condition, but prior to that time the injections were of limited value. The MAXIMUS physician consultant also noted that the medical records of 2004-2006 support the efficacy of the injection therapies for treatment of this patient's condition. The MAXIMUS physician consultant indicated the patient has failed back syndrome secondary to at least 6 surgeries and fusion and he had few treatment options left.

Therefore, the MAXIMUS physician consultant concluded that the injection tendon sheath/ligament (20550), injection Bupivacaine HCL 30 ml (S0020), injection triamcinolone acetonide per 10 mg (J3301) and special report (99080-73) on 7/8/05 were medically necessary.

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Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department