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: Pain and Recovery Clinic of San Antonio PO Box 240970 San Antonio, TX 78224	MDR Tracking No.: M5-06-1741-01 Previous No.: M4-06-0985-01 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.: 99F0000404710

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "Medically necessary treatment."

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)
5-2-05 – 6-7-05	CPT code 99212-59 ($44.16<MAR X 14 DOS)	☒ Yes ☐ No	$618.24
5-2-05 – 6-7-05	CPT code 97110-GP ($33.56 MAR X 48 units)	☒ Yes ☐ No	$1,610.88
5-2-05 – 6-7-05	CPT code 97140-59 ($31.73<MAR X 13 units)	☒ Yes ☐ No	$412.49
5-2-05 – 6-7-05	CPT code 97112 ($35.21 MAR X 6 units)	☒ Yes ☐ No	$211.26
5-2-05 – 6-7-05	CPT code 97035 ($14.63 MAR X 2 units)	☒ Yes ☐ No	$29.26
Total			$2,882.13

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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is $2,882.13.

Code 97010 on 5-18-05 and 5-19-05 was denied as "97-global". This service is a bundled service code and considered to be an integral part of a therapeutic procedure(s). Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code. The addition of the modifier "25" is not adequate. Therefore, additional payment cannot be recommended.

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 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 additional reimbursement in the amount of $2,882.13. 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	7-3-06
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 29, 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 #: M5-06-1741-01
DWC #: ___
Injured Employee: ___
Requestor: Pain & Recovery Clinic of San Antonio
Respondent: Texas Mutual
MAXIMUS Case #: TW06-0099

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 riding a lawnmower, the bumps and jarring motions caused low back pain that steadily progressed. Diagnoses included lumbar facet syndrome, lumbar sprain/strain, low back pain resistant to conservative measures, severe osteochondritis dissecans and left sacroiliitis. Evaluation and treatment has included chiropractic services, an MRI, medications, and injections.

Requested Services

Office visits (99212), therapeutic exercises (97110), manual therapy technique (97140), ultrasound (97035) and neuromuscular re-education (97112) from 5/2/05-6/7/05.

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

Documents Submitted by Requestor:

1. Records and Correspondence from David Griffith, DC – 2/14/056/14/06
2. Pain Management Records and Correspondence – 4/20/05-6/30/05
3. Designated Doctor Report – 4/28/05

Documents Submitted by Respondent:

None submitted.

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 chiropractor consultant indicated the patient was under an active care program that involved a multidisciplinary form of care that included manipulation, therapy, injections and pain medication. The MAXIMUS chiropractor consultant noted that over time he steadily improved and was released to full duty work with no restrictions for his back. The MAXIMUS chiropractor consultant also noted he had a separate knee issue that will require surgery that is non-compensation related. The MAXIMUS chiropractor consultant explained that a designated doctor evaluation on 4/28/05 found the patient to not be at a maximum medical improvement and suggested that he needed 3 more months before that would happen. The MAXIMUS chiropractor consultant indicated that the care in question was supportive of the injections and the desired outcome was attained. The MAXIMUS chiropractor consultant noted that treatment that leads to resolution of pain and a return to work status is medically necessary as in this case. (Mercy Guidelines, Haldeman, 1993)

Therefore, the MAXIMUS physician consultant concluded that the requested office visits (99212), therapeutic exercises (97110), manual therapy technique (97140), ultrasound (97035) and neuromuscular re-education (97112) from 5/2/05-6/7/05 were medically necessary for treatment of the member's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department