



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-1763-01
Valley Spine Medical Center 5327 South McColl Rd. Edinburg, Texas 78539	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Texas Mutual Insurance Company, Box 54	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary (Table of Disputed Services) states, "The care rendered to the patient has met criteria set by Texas Labor code section 408.21 complete rationale for increase reimbursement can be found in the medical records of the complete Medical Dispute."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

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

Position statement submitted by Texas Mutual does not address the disputed issues.

Principle Documentation:

1. DWC-60 Response

#### 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)
8-23-05 – 9-22-05	97035 (\$14.63 x 13 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$190.19
8-23-05 – 9-22-05	97110 (\$33.56 x 33 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,107.48
10-13-05, 10-14-05	99212-25 (\$45.26 x 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$90.52
11-01-05	E0745	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$111.89
8-23-05 – 11-1-05	97140, 97140-59, 97110, 97035 (except as noted above)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total Due		\$1,500.08

#### 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 \$1,500.08.

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.

On 6-29-06 the Medical Review Division submitted a Notice to Requestor to submit additional documentation necessary to support the charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the Requestor's receipt of the Notice.

CPT code 62282 on 11-11-05 was denied by the Respondent as "16-Service lacks information which is needed for adjudication," "207-Need valid Texas Fee Guideline Code, and "W-4-No additional reimbursement after reconsideration." The Requestor provided documentation to support Lumbar ESI per Rule 133.307(g)(3). Per the 2002 Medical Fee Guideline CPT code 62282 is a valid CPT code. Reimbursement of \$466.35 is recommended.

HCPCS code A4550 on 11-11-05 was denied by the carrier as "97-Payment is included in the allowance for another procedure," and "284-No allowance recommended as the procedure has a Medicare Status of B-Bundled," and "W-4-No additional reimbursement after reconsideration." Per the 2002 Medical Fee Guideline this is a bundled code. The services will not be paid separately.

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

28 Texas Administrative Code Sec. 133.1, 133.307, 133.308, 134.1 and 134.202(c)(1)  
Texas Labor Code 413.011 and 413.031

#### 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 \$1,966.43. The Division hereby **ORDERS** the Respondent 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

10-27-06

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.**

# MAXIMUS

July 19, 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 #: M5-06-1763-01**

**DWC #:**

**Injured Employee:**

**Requestor: Valley Spine Medical Center**

**Respondent: Texas Mutual**

**MAXIMUS Case #: TW06-0109**

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 \_\_\_\_\_ He reported that while doing heavy lifting, he developed severe pain in the low back radiating to the lower extremities with a pain level of 6+ on a scale of 1-10. Diagnoses included lumbosacral radiculopathy, spondylolisthesis, and multiple herniated discs. Evaluation and treatment has included medications, physical therapy, and epidural steroid injections.

### Requested Services

Ultrasound (97035), therapeutic exercises (97110), manual therapy technique (97140), office visits (99212-25) and neuromuscular stimulation (E0745) from 8/23/05-11/1/05.

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

*Documents Submitted by Requestor:*

1. Request for Reconsideration – 11/18/05, 11/30/05, 1/16/06, 1/25/06
2. Diagnostic Studies (e.g., MRI, etc.) – 9/12/05
3. Valley Spine Medical Center Records and Correspondence – 8/11/05-1/27/06

*Documents Submitted by Respondent:*

None submitted.

## **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 ultrasound is a beneficial means to penetrate deep into tissue to reduce adhesions, decrease pain and increase circulation. The MAXIMUS chiropractor consultant noted that it is only accepted in the acute phase (first 4 weeks) and then it becomes contraindicated. The MAXIMUS chiropractor consultant also noted that office visits are needed to evaluate the patient's conditions and to make appropriate determinations of future care. The MAXIMUS chiropractor consultant explained that a TENS unit is a highly effective and accepted means to control pain that is becoming chronic in nature. The MAXIMUS chiropractor consultant indicated there is lack of supporting documentation for 1½ hours of supervised therapies past 9/22/05. The MAXIMUS chiropractor consultant noted that 4 weeks of supervised care was sufficient to allow the patient to be properly trained in how to perform the activities at home without increased pain or injury. (Mercy Guidelines, Haldeman, 1993, National Guideline Clearinghouse, 2003, Rehab of the Spine, Liebenson, 1996.)

Therefore, the MAXIMUS physician consultant concluded that the ultrasound (97035) from 8/23/05-9/22/05, office visits (99212-25) from 10/13/05 and 10/14/05, and neuromuscular stimulation (E0745) on 11/1/05 were medically necessary for treatment of the member's condition. The MAXIMUS physician consultant also concluded that therapeutic exercises (97110), ultrasound (97035), neuromuscular stimulation (E0745) and all visits past 9/22/05 were not medically necessary for treatment of this member's condition.

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Sincerely,  
MAXIMUS

Lisa Gebbie, MS, RN  
State Appeals Department

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