



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: _____	MDR Tracking No.: M5-05-0056-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: HARTFORD UNDERWRITERS BOX 27	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 package and copy of paid receipts.
Position summary: I travel in construction and need meds while I travel back and forth to Texas.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 response and amended peer review.
Position summary: Denied for medical necessity per peer review.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-3-03 to 6-4-04	Spinal adjustments 1-2 areas and 3-4 areas	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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 disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Dee Z. Torres, Medical Dispute Officer

10-6-05

Authorized Signature

Typed Name

Date

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.

October 5, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-0056-01
TWCC #: _____
Injured Employee: _____
Requestor: _____
Respondent: Facility Insurance Company/Flahive-Ogden-Latson
MAXIMUS Case #: TW05-0148

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request

an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

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 with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 48-year old male who sustained a work related injury on _____. The patient reported while stepping down off a truck he twisted his ankle resulting in a fall. He also indicated he fell backwards striking his head on the truck's diesel fuel tank support injuring his ankle, mid back and cervical spine. Diagnoses include acute traumatic cervical brachial syndrome and thoracic sprain/strain. Treatment has included chiropractic treatments.

Requested Services

Spinal adjustments 1-2 areas and 3-4 areas from 11/3/03-6/4/04

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

Documents Submitted by Requestor:

1. None submitted.

Documents Submitted by Respondent:

1. Chiropractic Initial Report – 11/3/03
2. Initial Medical Reports – 1/22/97, 4/10/96
3. Specific and Subsequent Medical Reports – 5/1/92-7/21/98
4. Chiropractic Advisor Reviews – 4/30/97, 10/19/98
5. Notice of Utilization Findings – 10/5/98
6. Clinical Impressions/Treatment Plan – 7/21/98
7. Patient Progress Reports – 8/3/98-11/19/98
8. EMG/Muscle 2 Extremities Results – 11/10/98
9. Nurse Summary of File Review – 5/2/97
10. Case Discussion – 4/30/97

11. Retrospective Peer Review – 4/21/97
12. Operative Report – 4/3/97
13. Preauthorization for Myofascial Treatment – 3/27/97
14. Orthopaedic Surgery Evaluation – 12/1/05
15. Peer Review and Amended Peer Review– 6/21/04

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The MAXIMUS chiropractor consultant indicated the records reported that the member was injured in ___ from a fall. MAXIMUS chiropractor consultant noted he was originally diagnosed with cervical brachial syndrome and thoracic sprain/strain. The MAXIMUS chiropractor consultant explained that according to both the official disability guidelines of 2003 and the National Spine Society's guidelines for unremitting back pain, the member is far beyond the limits of treatment for the original diagnosis. The MAXIMUS chiropractor consultant also indicated that with the treating doctor adding a diagnosis of subluxation complex to the cervical spine, there was not enough evidence in the medical records to show the causal relationship between the injury from 11 years ago to treatments given to the member between 11/3/03 and 6/4/04. The MAXIMUS chiropractor consultant noted there is no evidence in the medical records that explains the exacerbation of the previous injury in terms of what happened to increase his symptoms and how the subluxation were caused from the brachial syndrome and thoracic sprain/strain from 11 years prior. The MAXIMUS chiropractor consultant noted there is no medical documentation to justify the medical necessity for the adjustments performed from 11/3/03 and 6/4/04. (Official Disability Guidelines, Work Loss Data Institute, 2003.)

Therefore, the MAXIMUS chiropractor consultant concluded that the spinal adjustments 1-2 areas and 3-4 areas from 11/3/03-6/4/04 were not medically necessary for treatment of this patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department