

MDR Tracking Number: M5-05-0722-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-01-04.

The IRO reviewed massage therapy, manual therapy, supplies/materials, therapeutic exercises, office visits, electrical stimulation, self care management training, chiropractic manipulative treatment, mechanical traction, neuromuscular re-education, group therapeutic procedures and special reports rendered from 01-15-04 through 07-02-04 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review 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 the Medical Review Division.

On 12-01-04, 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.

Review of CPT codes 98941, 97110, 97124, 99213, 97012, 97112, 97535, 99080 and 99070 rendered on 05-07-04, 05-10-04, 05-12-04, 05-14-04, 05-21-04, 05-26-04, 06-04-04, 06-09-04, 06-11-04, 06-23-04 and 06-25-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement recommended.

This Findings and Decision is hereby issued this 21st day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh
Enclosure: IRO Decision

January 20, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-0722-01
TWCC #:
Injured Employee:
Requestor: Suhail Al-Sahli, D.C.
Respondent: Ins. Co. of the State of PA c/o Flahive Ogden & Latson
MAXIMUS Case #: TW04-0505

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 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 61 year-old female who sustained a work related injury on _____. The patient reported that while at work she injured her back. 07/9/01 the patient underwent a cervical and lumbar MRI and x-rays of the lumbar spine. A myelogram performed on 10/2/02 revealed lumbar scoliosis with accompanying degenerative disc and degenerative joint disease, disc bulge at L2-3, L4-5 spondylosis, and L5-S1 hypertrophic spurs, cervical spondylosis at C3-4, C5-6, C6-7, and bony spurring at the C3-4, C5-6, and C6-7. The diagnoses for this patient have included chronic neck pain, status post cervical fusion surgery, cervical facet syndrome, right greater than left, chronic low back pain, lumbar radiculopathy, lumbar facet syndrome, right greater than left, sacroiliac dysfunction bilaterally, right greater than left, and regional myositis. Initial treatment for this patient's condition included therapy consisting of manipulation and cervical spine stretching, medication and spinal surgery.

Requested Services

Massage therapy, manual therapy, supplies/materials, therapeutic exercises, office visits, electrical stimulation, self care mgmt training, chiropractic manipulative treatment, mechanical

traction, neuromuscular reeducation, group therapeutic procedures, special reports from 1/15/04 through 7/2/04.

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

Documents Submitted by Requestor:

1. Position Paper 12/8/04
2. Office Notes 1/10/04 - 5/14/04
3. FCE 6/27/02
4. Pain Management notes 8/22/03 – 3/10/04
5. EMG/NCV 7/20/01
6. MRI report 7/9/01
7. X-ray report 7/9/01

8. Myelogram report 10/2/02

Documents Submitted by Respondent:

1. No documents submitted

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a 61 year-old female who sustained a work related injury to her back on _____. The MAXIMUS chiropractor reviewer also noted that the diagnoses for this patient have included chronic neck pain, status post cervical fusion surgery, cervical facet syndrome, right greater than left, chronic low back pain, lumbar radiculopathy, lumbar facet syndrome, right greater than left, sacroiliac dysfunction bilaterally, right greater than left, and regional myositis. The MAXIMUS chiropractor reviewer further noted that treatment for this patient's condition has included massage therapy, manual therapy, therapeutic exercises, electrical stimulation, chiropractic manipulative treatment, mechanical traction, neuromuscular reeducation, and group therapeutic procedures. The MAXIMUS chiropractor reviewer indicated that although the patient had continued complaints of pain, it is unclear whether the pain was related to the work related injury sustained on _____. The MAXIMUS chiropractor reviewer explained that the documentation provided does not demonstrate that the care this patient received was to treat her work related injury.

Therefore, the MAXIMUS chiropractor consultant concluded that the massage therapy, manual therapy, supplies/materials, therapeutic exercises, office visits, electrical stimulation, self care mgmt training, chiropractic manipulative treatment, mechanical traction, neuromuscular reeducation, group therapeutic procedures, special reports from 1/15/04 through 7/2/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department