

MDR Tracking Number: M5-05-0843-01

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 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. The dispute was received on 11-08-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the mechanical traction therapy, chiropractic manipulation, manual therapy, distinct procedural service, electrical stimulation, therapeutic exercises, vasopneumatic device therapy, physical medicine procedure, extraspinal, one or more regions, cardiovascular procedure, assistive technology assess and ultrasound therapy were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 12-15-03 to 01-19-04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 22nd day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO decision

February 18, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-0843-01
TWCC #:
Injured Employee:
Requestor: Southeast Health Services
Respondent: Texas Mutual Ins.
MAXIMUS Case #: TW05-0009

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 male who sustained a work related injury on _____. The patient reported that while at work he was injured in an automobile accident. Initial treatment consisted of ice, heat, and physio-therapy manipulations. The diagnoses for this patient have included acute lumbosacral strain, acute thoracic strain, and left trapezius strain. An MRI of the lumbar spine performed on 12/9/03 revealed a 2mm broad based protrusion of the 4th lumbar intervertebral disc that appeared to mildly efface the anterior surface of the thecal sac, and mild disc degenerative changes at the 5th lumbar intervertebral disc with a 2-3mm broad based protusion extended into the epidural fat, mildly effacing the anterior surface of the thecal sac and appearing to slightly efface the anterior aspect of the right and left L5-S1 nerve sleeves.

Requested Services

Mechanical traction therapy, chiropractic manipulation, manual therapy, distinct procedural service, electrical stimulation, mechanical traction therapy, therapeutic exercises, vasopneumatic device therapy, physical medicine procedure, extraspinal, one or more regions, cardiovascular procedure, assistive technology assess, ultrasound therapy from 12/15/03 – 1/19/04.

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

Documents Submitted by Requestor:

1. Initial Consultation 11/18/03
2. MRI report 12/9/03
3. Impairment Rating 2/5/04

4. FCE 1/19/04
5. Daily Notes 12/15/03 – 2/5/04

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 male who sustained a work related injury to his back on _____. The MAXIMUS chiropractor reviewer also noted that the diagnoses for this patient have included acute lumbosacral strain, acute thoracic strain, and left trapezius strain. The MAXIMUS chiropractor reviewer further noted that treatment for this patient's condition has included mechanical traction therapy, chiropractic manipulation, manual therapy, electrical stimulation, mechanical traction therapy, therapeutic exercises, vasopneumatic device therapy, and physical medicine. The MAXIMUS chiropractor reviewer explained that the treatment this patient received was medically necessary to treat his condition. Therefore, the MAXIMUS chiropractor consultant concluded that the mechanical traction therapy, chiropractic manipulation, manual therapy, distinct procedural service, electrical stimulation, mechanical traction therapy, therapeutic exercises, vasopneumatic device therapy, physical medicine procedure, extraspinal, one or more regions, cardiovascular procedure, assistive technology assess, ultrasound therapy from 12/15/03 – 1/19/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department