MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: ( ) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (X) No
Requestor's Name and Address **Dr. Suhail Al-Sahli** **1210A Nasa Rd. 1** **Houston, Texas 77058**	MDR Tracking No.: M5-05-1906-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address TASB Risk MGMT Fund, Box 12	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
3-22-04	**7-15-04**	**CPT codes 99212, 99213, 98940, 98941, 98943, 97110, 971245, 97012, 97112**	☒ **Yes** ☐ **No**
		(CPT Code 98943 is not covered by Medicare and is not reimbursable.)	☒ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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 prevailed on the disputed medical necessity issues. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge). The total amount due for the medical necessity issues is $3,455.17.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of $460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order. The total amount due for the medical necessity issues is $3,455.17.

Findings and Decision by:

	Donna Auby	6-20-05
Ordered by:		
	Margaret Q. Ojeda	6-20-05
Authorized Signature	Typed Name	Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

MAXIMUS®

HELPING GOVERNMENT SERVE THE PEOPLE®

June 17, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-1906-01
TWCC #: ___
Injured Employee: ___
Requestor: Dr. Suhail Al Sahli
Respondent: TASB Risk Management Fund
MAXIMUS Case #: TW05-0093

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 female who sustained a work related on ___. The patient reported that while at work she was assaulted by a mentally retarded student whom she was assisting to dress. She injured her cervical and lumbar spine. The patient underwent plain film x-rays and MRIs of the cervical and lumbar spines and shoulder on 3/23/00. On 3/9/04, she underwent percutaneous needle localization of the right sarcoiliac joint, arthrogram, and intra-articular

sacroiliac joint injection under fluoroscopy. Treatment for this patient's condition consisted of active rehabilitation exercise, stretching activities, strengthening exercises, chiropractic manipulation and passive modalities.

Requested Services

99212/99213 office visits, chiropractic manipulative treatment, therapeutic exercises, massage therapy, mechanical traction, neuromuscular re-education from 3/22/04 through 7/15/04.

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

Documents Submitted by Requestor:

1. Request for Reconsideration 5/16/05
2. Initial Evaluation 10/8/03
3. Progress Notes 2/11/04-5/21/04
4. MRI & X-ray reports 3/23/00
5. Pain Management Assessments 12/5/03 & 5/24/04
6. Operative report 3/9/04

Documents Submitted by Respondent:

1. No documents submitted

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her cervical and lumbar spine on ___. The MAXIMUS chiropractor reviewer also noted that on 3/9/04, she underwent percutaneous needle localization of the right sarcoiliac joint, arthrogram, and intra-articular sacroiliac joint injection under fluoroscopy and that further treatment of this patient's condition included active rehabilitation exercise, stretching activities, strengthening exercises, chiropractic manipulation and passive modalities. The MAXIMUS chiropractor reviewer explained that given this patient's work related injury history, the treatment rendered was medically appropriate. The MAXIMUS chiropractor reviewer also explained that the postoperative rehabilitation this patient received was to provide strengthening and to treat this patient's pain level. The MAXIMUS chiropractor reviewer further explained that this patient responded well to the treatment rendered. Therefore, the MAXIMUS chiropractor consultant concluded that the 99212/99213 office visits, chiropractic manipulative treatment, therapeutic exercises, massage therapy, mechanical traction, and neuromuscular re-education from 3/22/04 through 7/15/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department