

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Brett L. Garner DC PO Box 550496 Houston TX 77255	MDR Tracking No.: M5-05-1929-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Rep Box # 54 Texas Mutual Insurance	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		
2-4-04	5-7-04	99212, 99214, 97140, 97110, 97112, 97032, 97750-FC, 99373, E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2-3-04	2-3-04	97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 did **not** prevail on the disputed medical necessity issues.

The disputed dates of service 11-3-03 to 1-30-04 are untimely and ineligible for review per TWCC Rule 133.308 (e)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute.

Code 97110 for date of service 2-3-04 had no EOB submitted by either party. The requestor did not provide convincing evidence of receipt of request for EOB. Therefore, no review for this DOS and no reimbursement recommended.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Authorized Signature

Date

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 the TWCC Chief Clerk of Proceedings/Appeals Clerk must receive it within 20 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 Representative's 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 en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

MAXIMUS®

HELPING GOVERNMENT SERVE THE PEOPLE®

July 15, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-1929-01
TWCC #:
Injured Employee: ____
Requestor: Brett L. Garner, DC
Respondent: TX Mutual Insurance Company
MAXIMUS Case #: TW05-0072

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 injured his right shoulder after repeatedly lifting heavy articles. An MRI performed on the right shoulder was reported to have shown tendinosis and tendinopathy of the supraspinatus aponeurosis without evidence for a full thickness rotator cuff tear. An EMG performed on 2/6/03 indicated nerve root dysfunction bilaterally at the C7-8 level. Postoperatively the patient was treated with rehabilitation therapy. The patient underwent an anterior cervical discectomy and foraminotomy at the C6-7 levels with ACIF C-C7 with insertion of hardware. On 7/23/04 the patient underwent right shoulder surgery and was treated with postoperative rehabilitation therapy.

Requested Services

99212-ov, manual therapy technique, therapeutic exercises, neuromuscular reeducation, electrical stimulation, 99214-ov, durable medical equipment, functional capacity evaluation, and a telephone call to patient from 2/4/04 through 5/7/04.

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

Documents Submitted by Requestor:

1. Position Statement (no date)
2. MRI reports 1/27/03, ____
3. EMG reports 2/19/04
4. FCE reports 5/5/03, 3/17/04
5. Impairment Evaluation reports 6/17/04
6. Radiology report 7/26/02
7. Orthopedic reports 1/22/03 - 8/3/04
8. Otolaryngology reports 11/20/03 – 3/5/04
9. Medical reports (several)

Documents Submitted by Respondent:

1. None submitted

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that there were no SOAP notes that documented treatment or progress from November 2003 to May 2004. The MAXIMUS chiropractor reviewer further noted that SOAP notes for this period of time were requested from the provider. The MAXIMUS chiropractor reviewer indicated that the records provided by the provider reported no information that supported the need for the care provided from November 2003 to May 2004. The MAXIMUS chiropractor reviewer explained that there was no clinical or subjective benefit from the care offered during the period in question and therefore it was not medically necessary for treatment of the member's condition.

Therefore, the MAXIMUS chiropractor consultant concluded that the 99212-ov, manual therapy technique, therapeutic exercises, neuromuscular reeducation, electrical stimulation, 99214-ov, durable medical equipment, functional capacity evaluation, and a telephone call to patient from 2/4/04 through 5/7/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department