

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 Ronald Grabowski, D. C. 1710 S. Dairy Ashford, Ste 109 Houston, TX 77077	MDR Tracking No.: M5-05-2041-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance, Box 28	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		
3-24-04	10-13-04	CPT codes 99213, 97110, 97012, 98941	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 1-21-04 through 3-17-04.

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.

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 requestor's amount billed will be reimbursed for each date of service.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues. The total amount due for medical necessity issues is \$1,215.00.

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 totaling \$1,215.00, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna D. Auby

6-14-05

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.

June 10, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2041-01
TWCC #: ____
Injured Employee: ____
Requestor: Ronald Grabowski, DC
Respondent: Liberty Mutual Fire Insurance
MAXIMUS Case #: TW05-0092

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 underwent an MRI of the cervical spine and left shoulder performed on 11/26/03 revealed a dorsal annular bulge C5-6 and minimal annular bulging at the C6-7 level, tendinosis/tendonitis of the infraspinatus tendon with a small effusion in the subdeltoid bursa, hypertrophy of the AC joint with a Type II curved acromion, partial tear of the posterior inferior glenoid labrum with associated periosteal elevation of the capsule, and degenerative type I SLAP abnormality. MRI of the lumbar spine performed on 12/5/03 showed intervertebral osteochondrosis of L5-S1 with reactive modic type I and II endplate degenerative changes, and focal left parasagittal herniation 4-5mm showing early extrusion characteristics dorsal to the S1 endplate. Treatment for this patient's condition has included hot packs, chiropractic manipulation, traction, therapeutic exercises, ultrasound, electrical stimulation, and injections.

Requested Services

Office visit, therapeutic exercises, mechanical traction, chiropractic manipulation from 3/24/04 through 10/13/04.

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

Documents Submitted by Requestor:

1. Letter from Provider 5/9/05
2. MRI report 11/26/03 and 12/5/03
3. Operative Notes 12/16/03 – 9/14/04
4. Required Medical Exam 2/20/04
5. FCE 10/14/04
6. Office Notes 11/14/03 – 10/13/04

Documents Submitted by Respondent:

1. Preliminary Chiropractic Modality Review 3/1/05
2. Chiropractic Modality Review 3/11/04
3. Concurrent Management 12/22/03, 10/12/04
4. MRI report 11/26/03, 12/5/03
5. Office/Treatment notes 12/17/03 – 5/24/04
6. Operative Report 8/7/04
7. FCE 9/29/04

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted the member suffered a multi-level injury of his cervical and lumbar spines and of the shoulder. The MAXIMUS physician reviewer indicated he needed a multi disciplinary approach to treatment of his condition. The MAXIMUS physician reviewer noted that the care in dispute is primarily therapeutic therapy given after his injections and/or surgery on the shoulder. The MAXIMUS physician reviewer also noted this therapy was an important part of his treatment plan and progress. The MAXIMUS physician reviewer further noted the member ultimately met the goals of treatment and returned to work with no restrictions on 10/22/04. The MAXIMUS physician reviewer noted that due to the extreme amount of injury to three parts of his body, it is reasonable to expect complete recovery to take a lengthy period of time. Therefore, the MAXIMUS physician consultant concluded that the requested office visit, therapeutic exercises, mechanical traction, and chiropractic manipulation from 3/24/04 through 10/13/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department