

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 Richard Taylor MD 1920 South Loop 256 Palestine TX 75801	MDR Tracking No.: M5-05-2693-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Rep Box # 19 American Home Assurance	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		
11-29-04	1-12-05	97012, 97032, and 97110	<input checked="" type="checkbox"/> Yes <input 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 **prevailed** on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals \$1,419.36. The MAR for 97012 is \$17.91/unit x 2 = \$35.82. The MAR for 97032 is \$18.73. The MAR for 97110 is 34.46 per the 2002 MFG.

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 \$650.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and \$1,419.36 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.

Ordered by:

Authorized Signature

Typed Name

8-5-05

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

YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005 should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

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

August 2, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2693-01
TWCC #: _____
Injured Employee: _____
Requestor: Dr. Richard Taylor
Respondent: American Home Assurance
MAXIMUS Case #: TW05-0146

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 physician on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 30-year old female who sustained a work related injury on _____. The patient reported that while at work she fell. She was diagnosed with a lumbar herniated disc. She was initially treated conservatively with epidural steroid injections and vertical axial decompression treatments. These treatments were successful in relieving her pain. Two years later she had an exacerbation of symptoms. Treatment of her condition included therapeutic exercises, mechanical traction and electrical.

Requested Services

97110-therapeutic exercises, 97012-mechanical traction, 97032-electrical stimulation from 11/29/04-1/12/05.

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

Documents Submitted by Requestor:

1. Letters of Medical Necessity – 1/14/05, 3/4/05, 10/16/03, 12/16/02, 12/11/02, 2/27/02, 2/28/02
2. Physician Records – _____-5/17/05

3. Spine Impairment Summary – 1/9/04
4. Reports of Operation/Procedure – 12/5/01-12/31/04
5. Occupational Therapy notes – ___-3/28/05
6. Patient Pain Drawings – 12/5/01-5/17/05
7. Radiology Reports – 12/16/01-12/10/03
8. Orthopedic, Spine and Sports Medicine Evaluation – 2/4/03-4/8/03
9. Pain Clinic Records – 9/24/04
10. Neurosurgery notes – 1/29/02-8/6/02
11. Electrophysiological & Nerve Conduction Study – 12/24/02
12. Office Notes - 10/11/02-11/8/02
13. Care Clinic DRX Notes – 9/23/02-1/12/05
14. Physical Therapy Notes – 2/18/02-2/26/02
15. Functional Capacity Evaluation – 5/15/03

Documents Submitted by Respondent:

1. Retrospective Review Reports - 12/9/04, 12/13/04, 12/16/04, 12/20/04, 12/29/04, 1/3/05, 1/7/05, 1/11/05, 1/16/05, 1/23/05, 1/25/05, 4/22/05
2. Spine Resource Consultants Report – 5/21/01
3. Report of Operation/Procedure – 12/5/01-12/31/04
3. Letter of Medical Necessity – 2/27/02-3/5/05
4. Employer’s First Report of Injury or Illness – ___
5. Occupation Medicine Clinic Notes – ___-7/26/02
6. Neurosurgery notes - 1/29/02, 4/30/02, 6/3/02, 8/6/02
7. Electrophysiological Study – 12/24/02
6. Orthopedic, Spine and Sports Medicine Evaluation – 3/24/05
7. Functional Capacity Evaluation – 5/15/03
8. Privileged and Confidential Report – 11/10/03
9. Spine Impairment Summary – 1/9/04
10. Physician Record – 1/27/04-12/31/04
11. Orthopedic & Sports Medicine Evaluation and Follow-up Notes – 2/4/03-4/8/03
12. Physical Therapy Notes – 12/6/01-5/30/03
13. Care Clinic DRX Notes – 9/23/02-1/12/05
14. Radiology Reports – 12/6/01-12/10/03
15. Care Clinic Notes – 10/14/02-12/24/03

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer indicated that this 30-year old female had a work related injury on ___ with herniated disc that was treated with medication, physical therapy and epidural steroid injections. The MAXIMUS physician reviewer noted she returned to light duty work and reached maximum medical improvement on 1/9/04. The MAXIMUS physician reviewer explained she had recurrent pain in June 2004 and was treated initially with medication. The MAXIMUS physician reviewer also noted physical therapy was restarted on 11/29/04 and continued through 3/28/04. The MAXIMUS physician reviewer explained the patient received spinal decompression treatments, mobilization and instructions for stabilization exercises. The MAXIMUS physician reviewer indicated progress notes reported no consistent change or decrease in the level of pain. The MAXIMUS physician reviewer noted the patient reported her lowest degree of pain was 2 and the highest level was 7 on a scale of 1-10. The MAXIMUS physician reviewer also noted that a short re-trial of decompression treatments and physical therapy for recurrent low back pain was medically necessary and indicated from 11/29/04-1/12/05 for treatment of her condition.

Therefore, the MAXIMUS physician consultant concluded that 97110 - therapeutic exercises, 97012 - mechanical traction, and 97032 - electrical stimulation from 11/29/04-1/12/05 were medically necessary to treat the patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
Appeal Officer, State Appeals