

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestor's Name and Address: Joseph Siragusa, D. C. P.O. Box 3271 McAllen, Texas 78502	MDR Tracking No.: M5-05-2732-01 Former # – M5-05-2265-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Liberty Mutual, Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS - MEDICAL NECESSITY ISSUES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
5-3-04	9-20-04	99213, 99214, 97140 , 97035, G0283, 97110, 97112, 97530	<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 the requestor for the medical necessity services is \$3,946.29.

### 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 \$3,946.29. plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

Donna Auby

8-11-05

Ordered by:

Margaret Ojeda

8-11-05

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

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 in 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 - Revised

**RE: MDR Tracking #: M5-05-2732-01**  
**TWCC #: \_\_\_\_**  
**Injured Employee: \_\_\_\_**  
**Requestor: Joseph Siragusa, DC**  
**Respondent: Liberty Mutual**  
**MAXIMUS Case #: TW05-0108**

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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This chiropractor is a chiropractor and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating chiropractors or providers or any of the chiropractors 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 25-year old male who sustained a work related on \_\_\_\_\_. The patient reported that while driving and wearing a seatbelt, a truck hit his vehicle from behind. He sustained neck, shoulder and back injuries. He first sought medical attention on 2/20/04. Diagnoses of cervical sprain/strain, lumbar sprain/strain, deep and superficial spasm, and lumbar radiculitis were made. He began chiropractic treatment on 2/23/04. Treatment for this patient's condition consisted of epidural steroid injections, therapeutic exercises, neuromuscular re-education and manual therapy technique.

### Requested Services

Office visits (99213, 99214), chiropractic therapeutic exercises, therapeutic activities, ultrasound, electrical stimulation, neuromuscular re-education and manual therapy technique from 5/3/04-9/20/04.

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

*Documents Submitted by Requestor:*

1. Well Care Medical Clinic notes 2/20/04
2. MRI of the lumbosacral spine 3/9/04
3. Pain Medicine office visit note 3/10/04
4. NIT RGV Injury, Pain & Rehabilitation Center 7/29/04, 5/3/04
5. SOAP/Acute notes 5/13/04-9/20/04
6. Rio Grande Pain Team progress notes 5/11/04-7/28/04
7. Operative report 12/6/04
8. Rio Grande Orthopedic Center evaluation 7/14/04, 8/11/04, 9/22/04, 11/16/04
9. Lumbar discogram 11/11/04

*Documents Submitted by Respondent:*

1. NIT-RGV Neuromuscular Institute of Texas Initial evaluation 2/20/04
2. NIT-RGV Neuromuscular Institute of Texas re-evaluations 5/3/04, 9/13/04
3. MRI 3/9/04
4. Physical Performance Evaluations 5/13/04, 7/13/04
5. Operative reports 5/11/04, 7/6/04, 7/28/04, 8/16/04, 9/9/04
6. Follow-up reported 6/7/04, 7/13/04
7. Soap/Acute notes 5/13/04-9/20/04

Decision

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

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 indicated that the patient responded well to the treatment prescribed by his chiropractor. The MAXIMUS chiropractor reviewer noted that given the patient's history, injuries and number of injections required to treat the patient's condition, the post epidural injection therapy was medically necessary to alleviate pain and muscle spasms and to increase his level of functioning. The MAXIMUS chiropractor reviewer also indicated the office visits, chiropractic therapeutic exercises, therapeutic activities, ultrasound, electrical stimulation, neuromuscular re-education and manual therapy technique from 5/3/04-9/20/04 were medically necessary for treatment of this patient's condition.

Therefore, the MAXIMUS chiropractor consultant concluded that office visits (99213, 99214), chiropractic therapeutic exercises, therapeutic activities, ultrasound, electrical stimulation, neuromuscular re-education and manual therapy technique from 5/3/04-9/20/04 were medically necessary to treat this patient's condition.

Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department