



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0156-01
David M Griffith DC 30525 Quinn Road #A Tomball TX 77375	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Ace American Insurance Box 15	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package, EOBs, CMS-1500s. Position summary as listed on the table of disputed services: Carrier denied services without review of all documentation and treatment plan. They have failed to process our requests for reconsiderations or forward EOB's as well. Tx was necessary and beneficial to return pt back to work status. Pt had approved spinal injections and our tx was post injection related.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier did not respond.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-14-04 to 9-28-04	97110, 97112, 99214, 99354	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

Per Rule 133.308, date of service 9-13-04 was untimely and will not be a part of this review.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the 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:

_____, Medical Dispute Officer

11-16-05

Authorized Signature

Typed Name

Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

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

November 14, 2005
October 26, 2005

Texas Department of Insurance Division of Texas Worker's Compensation
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

Amended NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-06-0156-01
DWC #:
Injured Employee: ____
Requestor: David M. Griffith, DC
Respondent: Ace American Insurance Company
MAXIMUS Case #: TW05-0207

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308 which allows for a dispute resolution by an IRO.

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 condition and treatment options at issue in this appeal. The reviewer has met the requirements for the approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO, was signed. 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 male who sustained a work related injury on _____. The patient reported that he was lifting racks and packaging equipment when he felt a sudden onset of severe low back pain. He also reported complete numbness to his legs. Diagnoses have included a bulging disc at L5-S1 with left neuroforaminal narrowing and left nerve root abutment, and bilateral L5-S1 radiculopathy confirmed by Electromyography (EMG). Evaluation and treatment have included medication, physical medicine treatments, MRI, pain management, steroid injections and chiropractic treatments.

Requested Services

97110-therapeutic exercises, 97112-neuromuscular reeducation, 99354-prolonged physician services, 99214-office visit from 9/14/04-9/28/04.

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

Documents Submitted by Requestor:

1. Daily Progress Notes – 5/17/04-10/3/05
2. Initial and Follow-up Evaluations – 5/17/04-9/21/04
3. Request for MDR – undated
4. Independent Physician Review – 5/28/04
5. Work Hardening Assessment – 9/23/04
6. Pain Management Records – 4/1/04-9/7/04

7. Letter of Rebuttal – undated
8. TREK Mobil Diagnostics Records – 6/1/04-9/14/04
9. MRI – 12/19/03
10. EMG – 3/11/04

Documents Submitted by Respondent:

1. Independent Physician Review – 5/28/04

Decision

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

Standard of Review

This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this patient had undergone his third epidural injection and was totally pain free on 9/7/04. The MAXIMUS chiropractor reviewer indicated he underwent computerized muscle testing on 9/14/04 that showed him functioning at a medium level and he was able to return to work. The MAXIMUS chiropractor reviewer noted he had attained recovery at that point in time. The MAXIMUS chiropractor reviewer explained there is no medical necessity shown for ongoing therapy including prolonged office visits for a pain free man one year after his injury. The MAXIMUS chiropractor reviewer indicated there is no documentation that supports the chiropractic care was of any significant benefit in relieving his problems as the epidural injections did most of that. The MAXIMUS chiropractor reviewer also noted that his rehabilitation following epidural steroid injection could have been done at home, especially after the third injection. The MAXIMUS chiropractor reviewer indicated that some therapy was done at each visit even when the patient reported no pain. The MAXIMUS chiropractor reviewer noted there were no gains made after almost one year of care by two different chiropractors. The MAXIMUS chiropractor reviewer explained that the records show that on most visits the patient had more pain after therapy that is acceptable in the beginning of care, but not after 10-12 months of care.

Therefore, the MAXIMUS chiropractor consultant concluded that the 97110-therapeutic exercises, 97112-neuromuscular reeducation, 99354-prolonged physician services, 99214-office visit from 9/14/04-9/28/04 were not medically necessary for treatment of this patient's condition.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department