



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: Health Care Provider Injured Employee Insurance Carrier

Requestor's Name and Address:

Alan B. Hirschman, M. D.
 1550 W. Rosedale #406
 Fort Worth, TX 76104

MDR Tracking No.:

M5-06-1637-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Midwest Employers Casualty Company, Box 19

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "The patient has improved and shown demonstrated progress in her medical status since the injection therapy. The objective of the medical therapy is to send her back to full duty work. We are approaching maximum medical improvement."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines..."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-15-05 – 10-06-05	72020, Q9949, A4649, J1040, J2001, A4550, 72275, 94760, 99211, 64475, 64476	<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.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the disputed medical necessity issues. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
28 Texas Administrative Code Sec, 133.308 and 134.1

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 of the IRO fee and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

_____, Medical Dispute Officer

9-19-06

Authorized Signature

Typed Name

Date of Findings and Decision

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.

September 7, 2006

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-06-1637-01
DWC #: _____
Injured Employee: _____
Requestor: Alan B. Hurschman, MD
Respondent: Midwest Employers
MAXIMUS Case #: TW06-0105

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 physician who is board certified in orthopedic surgery 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 an adult female who had a work related injury on _____. Records report that she fell face down on rumpled, wavy, loose carpeting. Diagnoses have included low back pain, osteoporosis, spondylosis, and radiculopathy. Evaluation and treatment for this injury has included MRI, neurostimulator, medications, and physical therapy.

Requested Services

72020-Radiological examination, spine, single view, specify level, Q9949-Low osmolar contrast material, A4649-Surgical supply; miscellaneous, J1040, J2001-injections, A4550-Surgical trays,

72275-Epidurography, radiological supervision and interpretation, 94760-Noninvasive ear or pulse oximetry for oxygen saturation; single determination, 99211-Office visit, and 64475, 64476-injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve from 8/15/05-10/6/05.

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

Documents Submitted by Requestor:

1. None submitted.

Documents Submitted by Respondent:

1. Carrier's Position Statement – 5/25/06, 6/29/06
2. Review Determinations – 11/28/05
3. Peer Review Documents – 5/25/05, 10/20/05
4. Electrodiagnostic Studies – 10/26/04
5. Independent Medical Evaluation Report – 2/8/05
6. Celburne Physical Therapy records and correspondence – 12/16/04, 1/17/05
7. Texas Back Institute Fort Worth records and correspondence – 11/11/04

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 physician consultant indicated the patient has chronic arthritic back pain. The MAXIMUS physician consultant noted the literature does not support the case of facet injections for spondylosis and chronic low back pain. The MAXIMUS physician consultant explained that a meta-analysis of the literature by van Tulder clearly demonstrated that facet injections are not effective for this condition. (van Tulder MW, et al. Outcome of Invasive Treatment for Low Back Pain, Eur Spine J. 2006.)

Therefore, the MAXIMUS physician consultant concluded that 72020-Radiological examination, spine, single view, specify level, Q9949-Low osmolar contrast material, A4649-Surgical supply; miscellaneous, J1040, J2001-injections, A4550-Surgical trays, 72275-Epidurography, radiological supervision and interpretation, 94760-Noninvasive ear or pulse oximetry for oxygen saturation; single determination, 99211-Office visit, and 64475, 64476-injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve from 8/15/05-10/6/05 were not medically necessary for treatment of the member's condition.

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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.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department