

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 6-24-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The WH-CA 97545 and WH-CA 97546 on 8-28-03, 9-4-03 and 9-12-03 **were found** to be medically necessary. The WH-CA 97545 and WH-CA 97546 on 9-23-03, 9-24-03, 9-26-03, 9-29-03, and 10-2-03 through 10-8-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-01-04, the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT codes 97545 WH CA and 97546 WH CA on 8-26-03, 8-27-03, 8-29-03, 9-2-03, 9-3-03, 9-8-03, 9-10-03, 9-11-03, 9-15-03, 9-16-03, 9-17-03, 9-19-03, 9-22-03, 9-25-03, 9-30-03 and 10-01-03 were denied by the carrier with an "N" – "A peer review obtained by the carrier indicates that the documented services do not meet minimum fee guideline and/or the rules contained within in the applicable AMA CPT/HCPCS Coding Guidelines". Per Rule 133.307(g)(3)(B) The additional documentation shall include a copy of any pertinent medical records or other documents relevant to the fee dispute. The requestor sent no additional documentation or pertinent medical records to support the level of service rendered. **Recommend no reimbursement.**

CPT code 97750FC on 9-18-03 was denied with an F, "Reimbursement according to the Texas Medical Fee Guidelines." Ingenix Encoder Pro states that this service is a "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with **written report**, each 15 minutes. Per Rule 133.307(g)(3)(B) The additional documentation shall include a copy of any pertinent medical records or other documents relevant to the fee dispute. The requestor sent no additional documentation, written report or pertinent medical records to support the units of service rendered. **Recommend no reimbursement.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 8-28-03 through 9-12-03 as outlined above in this dispute.

This Decision and Order is hereby issued this _____ day of January, 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Enclosure: IRO decision

January 24, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter B 1/24/05

RE: MDR Tracking #: M5-04-3601-01
TWCC #:
Injured Employee:
Requestor: Rehab 2112
Respondent: Twin City Fire Insurance
MAXIMUS Case #: TW04-0358

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 reported that while at work he injured his right shoulder when a coke machine fell from a fork lift striking him on the right shoulder. The patient was initially treated with active rehabilitation consisting of therapeutic exercises and therapeutic procedures. In 8/03 the patient began a work hardening/conditioning program and subsequently released back to work with a 65 pound lifting restriction.

Requested Services

Work Hardening 97545 and Work Hardening 97546 on 8/28/03, 9/4/03, 9/12/03, 9/23/03, 9/24/03, 9/26/03, 9/29/03, and 10/2/03 through 10/8/03.

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

Documents Submitted by Requestor:

1. MDR Request 6/15/04
2. Daily Notes 8/26/03 – 10/8/03
3. Impairment Rating 11/25/03
4. FCE 8/25/03 and 10/13/03

Documents Submitted by Respondent:

1. Same as above

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his right shoulder on _____. The MAXIMUS chiropractor reviewer I

ndicated that the patient sustained a localized injury to the right shoulder that slowly improved over time. The MAXIMUS chiropractor reviewer noted that the patient was treated for approximately 4 weeks conservatively prior to being put in a an extensive work hardening program. The MAXIMUS chiropractor reviewer explained that a total body work hardening program is not medically necessary for a localized shoulder injury. The MAXIMUS chiropractor reviewer noted that 2 hours a day of work hardening was directed at the shoulder injury. The MAXIMUS chiropractor reviewer indicated that the rest of the treatment consisted of cardio-vascular and psychological treatment directed at the upper and lower back. The MAXIMUS chiropractor reviewer explained that this was a non-complicated case that did not require such extensive treatment. The MAXIMUS chiropractor reviewer also explained that the patient did not meet the TWCC requirements for a work hardening program. The MAXIMUS chiropractor reviewer further explained that the daily two hours of treatment directed at the shoulder injury from 8/28/03 9/4/03, and 9/12/03 were appropriate and medically necessary.

Therefore, the MAXIMUS chiropractor consultant concluded that the WH-CA (97545) and WH-CA 97546 on 8/28/03, 9/4/03, and 9/12/03 were medically necessary to treat this patient's condition. The MAXIMUS chiropractor consultant further concluded that the WH-CA 97545 and WH-CA 97546 on 9/23/03, 9/24/03, 9/26/03, 9/29/03, and 10/2/03 through 10/8/03 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department