THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-05-7891.M5

MDR Tracking #M5-05-2000-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-17-05.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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

The IRO reviewed the Work Hardening program that was denied for medical necessity from 6-22-04 through 8-20-04.

The Work Hardening program from 6-22-04 through 8-20-04 was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. **The amount due the requestor for the medical necessity issues is $8,320.00.**

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 4-20-05 the Medical Review Division submitted a Notice to 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 code 97546 WH on 6-30-04 was denied as "YF-Reduced or denied in accordance with the appropriate fee guideline ground rule and/or maximum allowable reimbursement.) Reimbursement is at the CARF rate according to 134.202 (e)(5)(C)(ii) at $64 per hour. **Recommend reimbursement of $384.00.**

CPT code 97545 WH and 97546 WH on 7-23-04, 8-4-04, 8-5-04, 8-9-04, 8-10-04, 8-12-04, 8-13-05 and 8-17-04 were denied as "JF-Documentation submitted does not substantiate the

service billed.) Requestor did not submit relevant documentation to support level of service per Rule 133.307(g)(3)(B) on 7-23-04, 8-13-04, and 8-17-04. **Recommend reimbursement of**

$2,560.00 for 8-4-04, 8-5-04, 8-9-04, 8-10-04 and 8-12-04 at the CARF rate according to 134.202 (e)(5)(C)(ii) of $64 per hour.

This Finding and Decision is hereby issued this 31st day of May, 2005.

Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling $11,264.00 from 6-22-04 through 8-20-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all acc___d interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Decision and Order is hereby issued this 31st day of May, 2005.

Associate Director, Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

MAXIMUS®

HELPING GOVERNMENT SERVE THE PEOPLE®

May 24, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2000-01
TWCC #:
Injured Employee: ___

Requestor: HealthReady
Respondent: Texas Mutual Insurance Company
MAXIMUS Case #: TW05-0084

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 back when he attempted to lift a heavy object. Initially the patient had been treated with medications and physical therapy. The treating diagnoses for this patient include lumbar intervertebral disc without myelopathy and thoracic or lumbosacral neuritis or radiculitis. Additional treatment for this patient's condition included a pain management program and a work hardening program.

Requested Services

WH-CA Work Hardening initial 2 hours (CARF accredited), WH-CA Work Hardening, additional hours (CARF accredited) from 6/22/04 – 8/20/04.

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

Documents Submitted by Requestor:

1. Letter of Medical Necessity (no date)
2. Work Conditioning Treatment Notes 6/22/04 – 8/3/04
3. Work Hardening Treatment Logs and SOAP Notes 4/1/04 – 8/20/04
4. Functional Capacity Evaluation 5/7/04

Documents Submitted by Respondent:

1. No documents submitted

Decision

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

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 participated in a pain management program and was found to be severely deconditioned and referred to work hardening. The MAXIMUS chiropractor reviewer explained that a work hardening program is a distinctly different program than a pain management program and that denying it as duplicated services is not reasonable. The MAXIMUS chiropractor reviewer noted that the patient demonstrated improvement with strength and conditioning and ultimately returned to work at a heavy work level. The MAXIMUS chiropractor reviewer explained that the goals of the work hardening program is to return the injured worker to his job at his previous work level or better. Therefore, the MAXIMUS chiropractor consultant concluded that the WH-CA Work Hardening initial 2 hours (CARF accredited), WH-CA Work Hardening, additional hours (CARF accredited) from 6/22/04 – 8/20/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department