



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Buena Vista Workskills 5445 La Sierra Dr. #204 Dallas, Texas 75231	MDR Tracking No.: M5-05-2123-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Trinity Universal Insurance Company	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the TWCC 60 package.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the TWCC 60 response.

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)
6-21-04 – 8-6-04	CPT codes 97545-WHCA and 97546 WHCA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$7,999.00

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.

CPT code 97545 WHCA and 97546 WHCA on 6-10-04 was paid by the carrier per a print-out supplied by the carrier. This service will not be a part of this dispute.

The Division has reviewed the enclosed IRO decision and determined that the requestor did prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$7,999.00.

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

On 4-28-05 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.

Regarding CPT code 97545 WHCA and 97546 WHCA on 8-4-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$448.00.

The total for the fee issues is \$448.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(c)(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 carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 20 days of receipt of this order. The Division has determined that the requestor is entitled to reimbursement in the amount of \$8,447.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20 days of receipt of this Order.

Findings and Decision and Order by:

Donna Auby

6-14-05

Margaret Ojeda

6-14-05

Authorized Signature

Typed Name

Date of Order

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.

June 10, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter 6/13/05

RE: MDR Tracking #: M5-05-2123-01
TWCC #:
Injured Employee: ____
Requestor: Buena Vista Workksills
Respondent: Harris & Harris
MAXIMUS Case #: TW05-0100

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 physician 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 physician is board certified in physical medicine and rehabilitation and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 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 patient who sustained a work related injury on _____. The patient reported that while at work, he injured his back when he attempted to place a ladder on the rack on top of his van. An MRI of his thoracic spine performed on 5/4/04 showed degenerative disc disease at T6-7 through T11-12 and intraosseous disc herniations of adjacent endplates at T8-9 as well as through inferior endplate of T11. An MRI of the lumbar spine was reported to have shown a 3mm left subarcicular and foraminal disc herniation at L4-5, flattening of thecal sac with moderate narrowing of left neuroforaminal space, impingement upon the exiting left L4 nerve root, a 3mm subligamentous herniation flattening the adjacent thecal sac at the L5-S1 level, and mild bilateral foraminal encroachment. Treatment for this patient's condition has included physical therapy, chiropractic treatment, medications and a work hardening program.

Requested Services

97545-WH-CA work hardening (CARF accredited), 97546-WH-CA work hardening, (CARF accredited) from 6/21/04 – 8/6/04.

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

Documents Submitted by Requestor:

1. Summary of Requestor's Position Regarding This Fee Dispute 3/2/05
2. Request for Reconsideration 9/8/04, 10/2/04
3. Initial Behavioral Medicine Consultation 6/10/04
4. Work Hardening Daily Flow Sheets/Notes 6/21/04 – 8/6/04

Documents Submitted by Respondent:

1. Retrospective Peer Review Report 12/31/04
2. Peer Review 7/27/04

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a female who sustained a work related injury to his back on _____. The MAXIMUS physician reviewer indicated that the patient was treated conservatively with physical therapy and chiropractic care, and attempted to return to work, but failed to achieve full duty status. The MAXIMUS physician reviewer indicated that MRIs of his thoracic and lumbar spines revealed degenerative joint disease and disc herniations at 2 levels. The MAXIMUS physician reviewer explained that a functional capacity examination performed on 5/10/04 found that this patient was capable of sedentary to light work. The MAXIMUS physician reviewer also explained that a behavioral medicine consultation obtained on 6/10/04 found that the patient had limited functional ability due to pain and related disturbances. The MAXIMUS physician reviewer noted that he received trials of physical therapy, chiropractic treatment and medications without resolution of his symptoms. The MAXIMUS physician reviewer indicated that this patient participated in a work hardening program from 6/21/04 to 8/6/04 and was found to be at a medium duty level at the end of the program. The MAXIMUS physician reviewer also indicated that although his pain level only improved minimally, the patient's functional capacity improved from sedentary/light duty to medium duty. The MAXIMUS physician reviewer explained that function centered rehabilitation increases the number of work days and lifting capacity in patients with non-acute non-specific back pain. (Archive of Physical Medicine and Rehabilitation, May 2005.) The MAXIMUS physician reviewer also explained that the work hardening that this patient received was function centered rehabilitation, which was effective in returning him to work. Therefore, the MAXIMUS chiropractor consultant concluded that 97545-WH-CA work hardening (CARF accredited), 97546-WH-CA work hardening, (CARF accredited) from 6/21/04 to 8/6/04 were medically necessary to treat this patient's condition.

Sincerely,

MAXIMUS

Elizabeth McDonald
State Appeals Department