

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address HighPoint Rehabilitation Institute 800 W Arbroom Blvd Suite 330 Arlington TX 76015	MDR Tracking No.: M5-05-2373-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Rep Box # 27 Hartford Underwriters	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
5-10-04	6-7-04	97545-WH-CA and 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review 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:

Authorized Signature

Typed Name

Date

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005 should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

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

July 27, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2373-01
TWCC #:
Injured Employee: ____
Requestor: Highpoint Rehab
Respondent: Hartford Underwriters Insurance
MAXIMUS Case #: TW05-0128

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 64 year-old male who sustained a work related injury to his back on _____. A MRI of the patient's thoracic spine performed on 3/26/04 showed disc desiccation at 2 levels with mild narrowing of the intervertebral disc height at T8-91 and T11-12, a minor degree of disc protrusion indenting only the anterior subarachnoid space in the lower spine and maintenance of vertebral height. A MRI of his left shoulder performed on 3/26/04 showed spur formation and edema in the left acromioclavicular joint, which was producing impingement on the supraspinatus muscle, a 1 cm full thickness tear at the rotator cuff, and fluid in the subacromial and subdeltoid bursa. Diagnoses for this patient include cervical radiculopathy, severe cervical spondylosis at C3-4 with right greater than left foraminal stenosis, spondylosis at L4-5, C5-6 anterolisthesis, rotator cuff tear and chronic pain syndrome. Treatment for the patient's condition has included physical therapy, medications, epidural steroid injections and a multidisciplinary work hardening program. On 2/10/05, the patient underwent an anterior cervical microdiscectomy of C3-4 with partial C3 corpectomy, resection of spurs, resection of thickened posterior longitudinal ligament, spinal cord and nerve root decompression, bilateral C3-4 foraminotomies with decompression of the exiting C4 nerve roots, exploration of the epidural space, placement of a spacer at C3-4, anterior cervical fusion of C3-4, anterior cervical microdiscectomy of C4-5, with partial C4 corpectomy, resection of spurs, resection of thickened posterior longitudinal ligament, spinal cord and nerve root decompression, bilateral C4-5 foraminotomies with decompression of the exiting C5 nerve roots, exploration of the epidural space, placement of a spacer at C-45, anterior cervical fusion of C4-5, anterior instrumentation of C3-5 and bone marrow harvest from the iliac crest. Postoperatively, he was treated with an external bone growth stimulator.

Requested Services

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

Documents Submitted by Requestor:

1. Request for reconsideration dated 12/14/04
2. Letter to the Carrier dated 7/26/04
3. Comprehensive medical analysis report dated 7/26/04
4. Functional capacity examination reports dated 4/20/04 and 6/9/04
5. Work hardening records from 5/10/04 to 6/9/04
6. Report from cervical x-rays, and cervical lumbar myelograms and CT scans performed on 1/16/04
7. Letter of medical necessity for a work hardening program dated 4/26/04
8. Chronic pain evaluation report dated 2/27/04
9. Neurosurgeon's records from 11/12/03 to 3/31/04

Documents Submitted by Respondent:

1. Physical therapy notes from 6/10/05 to 6/20/05
2. Neurosurgeon's records from ___ to 5/16/05
3. Report from x-rays of the cervical spine performed on 3/16/05 and 5/11/05
4. Therapist's treatment records from 12/9/03 to 1/8/04 and from 3/28/05 to 5/2/05
5. Anesthesia records dated 2/15/05
6. Hospital records dated 2/18/05 and 3/10/05
7. Operative report dated 2/10/05
8. Chest x-ray report dated 2/7/05
9. Reports from CT scans of the cervical spine performed on 12/15/04
10. Review determinations dated 11/21/03 to 1/10/05
11. Reports from functional capacity examinations performed on 4/20/04 and 6/9/04
12. Work hardening progress reports from 5/10/04 to 6/8/04
13. Letter of medical necessity for a work hardening program dated 4/26/04
14. Motor Nerve Study, Sensory Nerve Study and EMG report dated 11/7/03
15. Pain management records from 3/11/04 to 6/29/04
16. Letter dated 7/26/04
17. Comprehensive medical analysis report dated 7/26/04 Physical therapy records from 1/28/04 to 2/12/04
18. Chronic pain evaluation report dated 2/27/04
19. Employer's first report of injury or illness dated
20. Medical records dated 10/8/03 to 10/17/03
21. Letter of medical necessity for psychological evaluation, psychometric testing, health and behavioral assessment dated 1/30/04
22. Orthopedic surgeon's records from 10/28/03
23. Report from CT scan of the cervical spine performed on 10/15/03
24. Report from MRI scan of the cervical spine performed on 8/13/03
25. Report from x-ray of the shoulders performed on 8/8/03
26. Cervical evaluation report dated 1/27/03
27. Primary care physician records from 8/2/96 to 1/8/04
28. Report from x-rays of the cervical spine performed on 2/20/98

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a 64 year-old male with a history of multiple medical problems who sustained a work related injury on _____. The MAXIMUS physician reviewer also noted that the patient was treated with multiple modalities including pain medications, physical therapy, and steroid injection for his complaints of neck, shoulder and back pain. The MAXIMUS physician reviewer explained that the patient had not exhausted all other treatment options and had not reached maximum improvement with physical therapy prior to participation in this work hardening program. The MAXIMUS physician reviewer also explained that he continued to receive cervical and epidural steroid injections. The MAXIMUS physician reviewer indicated that the documentation submitted for review demonstrates that the patient had not received an adequate trial of a physical therapy and home exercise program prior to the beginning of this work hardening program. The MAXIMUS physician review also indicated that the documentation submitted for review demonstrates that he had not achieved maximal benefit from non-surgical treatment prior to starting this work hardening program.

Therefore, the MAXIMUS physician consultant concluded that 97545 WH CA and 97546 WHCA – Work Hardening Program from 5/10/04 to 6/7/04 were not medically necessary to treat this patient’s condition.

Sincerely,

MAXIMUS

Lisa K. Maguire, Esq.
Project Manager, State Appeals