

## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity Dispute

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestor's Name and Address  Main Rehab & Diagnostics 3500 Oak Lawn Suite 380 Dallas TX 75210	MDR Tracking No.: M5-05-2389-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address      Rep Box # 19  Lumbermen's Underwriting Alliance	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		
4-30-04	5-28-04	99203, 99213, 97110, 97150, 99212, 99211	<input checked="" type="checkbox"/> Yes <input 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 **prevailed** on the disputed medical necessity issues. The amount due from the carrier is \$3,117.91 for the medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review 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 the Medical Review Division.

On 6-7-05 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.

Code 99455-V5-WP billed for date of service 5-28-05 was paid at \$297.68. The requestor billed \$447.68 and is seeking an additional \$150.00. Requestor did not submit copy of MMI/IR report. Per Rule 134.202 (6)(C) & (D), the reimbursement for the MMI exam by the treating doctor is equal to the level of office visit plus the IR. Without the report, the appropriate IR reimbursement cannot be determined. Therefore, no additional reimbursement can be recommended.

**PART IV: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$3,117.91 plus all accrued interest due at the time of payment to the Requestor within 20 days of receipt of this Order.

Findings & Decision by:

8-4-05

Authorized Signature

Typed Name

Date

Ordered by:

8-4-05

Medical Necessity Team

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: \_\_\_\_\_

**PART VI: YOUR RIGHT TO REQUEST A HEARING**

**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.**

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

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-05-2389-01**  
**TWCC #:**  
**Injured Employee: \_\_\_\_**  
**Requestor: Main Rehab & Diagnostics**  
**Respondent: Lumberman's Underwriting/F.O.L.**  
**MAXIMUS Case #: TW05-0119**

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 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 an adult male who sustained a work related injury on \_\_\_\_ and was diagnosed with a bilateral hernia. He underwent bilateral hernia repairs on 2/2/04. The patient received physical therapy from 5/1/04 to 5/20/04. On 5/28/04, the patient was evaluated and found to be at maximum medical improvement.

### Requested Services

99203 OV, 99211 OV, 99212 OV, 99213 OV, 97110 therapeutic exercises, 97150 group therapeutic procedures from 4/30/04 to 5/28/04.

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

#### *Documents Submitted by Requestor:*

1. Letter of medical necessity dated 6/20/05
2. Designated Doctor Report dated 3/26/04
3. New Patient Examination report dated 4/30/04 and physical therapy records from 5/4/05 to 5/28/04

#### *Documents Submitted by Respondent:*

1. None 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 an adult who sustained a work related injury on \_\_\_ and underwent bilateral hernia repairs on 2/2/04. The MAXIMUS chiropractor reviewer explained that the patient responded well to the treatment he received from 4/30/04 to 5/28/04. The MAXIMUS chiropractor reviewer indicated that the records from this treatment document objective measures of his response to treatment.

Therefore, the MAXIMUS physician consultant concluded that the 99203 OV, 99211 OV, 99212 OV, 99213 OV, 97110 therapeutic exercises, 97150 group therapeutic procedures from 4/30/04 to 5/28/04 were medically necessary to treat this patient's condition.

Sincerely,

**MAXIMUS**

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