

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 Summit Rehabilitation Centers 2500 W Freeway #200 Fort Worth TX 76102	MDR Tracking No.: M5-05-2466-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Bankers Standard Ins Co Box 15	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		
5-17-04	7-16-04	97110, 99213, 97113, 97116, 98940	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10-12-04	10-12-04	98940	<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 disputed dates of service 5-11-04 through 5-13-04 are untimely and ineligible for review per TWCC Rule 133.308(e)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the majority of the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues is \$1,328.79.

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 6-23-05 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.

99213 billed on 6-17-04 and 7-16-04 had no EOB submitted by either party. The requestor submitted convincing evidence of carrier receipt of request for an EOB. Therefore, this review will be per the 2002 MFG. Recommend reimbursement of \$65.17 x 2 days = \$130.34.

95851 billed on 10-7-04 denied as global. Per the 2002 MFG, this code is global to the office visit billed on the same day. No reimbursement 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 this amount plus \$1,459.13 consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20 days of receipt of this Order.

Ordered by:

8-24-05

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 en español acerca de esta correspondencia, favor de llamar a 512-804-4812.

August 4, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2466-01
TWCC #: _____
Injured Employee: _____
Requestor: Summit Rehab
Respondent: Bankers Standard Insurance Company
MAXIMUS Case #: TW05-0129

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 a 53-year old male who sustained a work related injury to his back on _____. Diagnoses for this patient include displacement of cervical intervertebral disc with C6 radiculopathy into the right upper extremity, lumbar sprain complicated by a previous fusion and laminectomy at L5-S1, sprain of left hip, and left sacro-iliac joint, post single level fusion at L3-4,

closed fracture of left lower rib(s), and concussion with moderate loss of consciousness. Treatment for the patient's condition has included individual counseling, biofeedback, massage therapy, physical therapy, aqua therapy, Medrol dosepak, and steroid injections.

Requested Services

97110-Therapeutic Exercises, 99213-Office Visit, 97113-Aquatic therapy, 97116-Gait Training, 98940-Chiropractic Manipulation from 5/17/04-10/12/04.

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

Documents Submitted by Requestor:

1. Letter requesting appeal – 6/30/05
2. Clinical S.O.A.P. Notes – 5/11/04-3/2/05

3. Operative Report – 1/21/04
4. Neurosurgical note and follow-up clinic visit– 12/2/03-7/16/04
5. Procedure report – 10/1/04, 11/12/04

Documents Submitted by Respondent:

1. None

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that according to the medical records, the member underwent lumbar fusion surgery on 1/21/04. The MAXIMUS chiropractor reviewer also noted that he was released to begin post operative rehabilitation on 5/7/04 by his surgeon. The MAXIMUS chiropractor reviewer noted that according to the 2004 American College of Occupational and Environmental Medicine (ACOEM) official disability guidelines, post operative treatment for a lumbar fusion can last up to 16 weeks. The MAXIMUS chiropractor reviewer explained that post operative rehabilitation from 5/17/04-8/27/04 was medically necessary for treatment of this patient's condition. The MAXIMUS chiropractor reviewer also indicated there is no evidence to indicate that rehabilitation after 8/27/04 was necessary.

Therefore, the MAXIMUS physician consultant concluded that 97110-Therapeutic Exercises, 99213-Office Visit, 97113-Aquatic therapy, 97116-Gait Training, 98940-Chiropractic Manipulation from 5/17/04-8/27/04 were medically necessary to treat the patient's condition. The MAXIMUS physician consultant concluded that 97110-Therapeutic Exercises, 99213-Office Visit, 97113-Aquatic therapy, 97116-Gait Training, 98940-Chiropractic Manipulation from 8/28/04-10/12/04 were not medically necessary to treat the patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
Appeal Officer, State Appeals