

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X)HCP ()IE ()IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Injury One Treatment Center 5445 La Sierra Drive Suite 204 Dallas TX 75231	MDR Tracking No.: M5-05-2804-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Box 28	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		
4-5-05	5-5-05	97545-WH-CA and 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<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.

The carrier submitted proof of payment for code 90806 billed for dates of service 3-17-04, 3-24-04, and 4-7-04. Therefore, no dispute exists for these dates of service.

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

8-18-05

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.

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 #: M5-05-2804-01
TWCC #: ____
Injured Employee: ____
Requestor: Injury One Treatment Center
Respondent: Liberty Mutual
MAXIMUS Case #: TW05-0149

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 who sustained a work related injury on _____. The patient reported that while on break, a coworker came up from behind him and slapped him on the upper back around his neck. He also reported when he got hit, his head went back and he felt a pop. His diagnoses include intervertebral cervical disc syndrome, cervical hyperflexion/hyperextension, and cervical radiculitis neuritis. He was treated conservatively with medications, cortisone injections, behavioral health services and physical rehabilitation.

Requested Services

97545 WH-CA and 97546-WH-CA from 4/5/05-5/5/05

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

Documents Submitted by Requestor:

1. Summary of Requestor's Position – 6/20/05
2. Request for Behavioral Health Treatment – _____, 6/10/05
3. Individual Psychotherapy Plan & Goals of Treatment – 4/19/05, 6/10/05
4. MRI Thoracic Spine – 11/11/04
5. Initial Medical Narrative Report – 12/17/04
6. Assessments – 1/7/05, 1/4/05, 1/10/05
7. Psychotherapy Notes – 3/3/05, 3/11/05, 3/17/05, 3/24/05, 3/29/05, 4/7/05, 5/2/05
8. Physical Therapy Evaluation Work Hardening Program Report – 4/1/05
9. Functional Capacity Evaluations – 4/1/05, 4/29/05
10. Work Hardening Records - 4/5/05-5/5/05
11. Interdisciplinary Notes – 4/5/05-5/5/05

Documents Submitted by Respondent:

1. None

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer indicated the member sustained a work related injury on _____ that resulted in neck and shoulder and shoulder blade pain. The MAXIMUS physician reviewer noted the member was felt to have cervical disc syndrome and radiculitis/neuritis. The MAXIMUS physician reviewer explained the member received treatment including medication, cortisone injections and physical therapy. The MAXIMUS physician reviewer also noted the member had minimal response to these treatments and his pain level remained high (7-8). The MAXIMUS physician reviewer explained the member had a functional capacity evaluation (FCE) on 4/1/05 and on that day his pain level was 7/10. The MAXIMUS physician reviewer indicated the member reported increased pain and muscle spasms after various tests during the FCE. The MAXIMUS physician reviewer also indicated that the member was not ready for a work hardening program given his significant pain while undergoing a FCE until his pain level was reduced.

Therefore, the MAXIMUS physician consultant concluded that 97545 WH-CA and 97546-WH-CA from 4/5/05-5/5/05 were not medically necessary to treat the patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
Appeal Officer, State Appeals