



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: JARED BARKER OT 7125 MARVIN D. LOVE #107 DALLAS TX 75237	MDR Tracking No.: M5-05-3058-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: DALLAS ISD C/O HARRIS & HARRIS BOX 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 package, EOBs, CMS-1500s.
Position Summary: Services are medically necessary. The peer review used to deny our service was dated 5-15-02; our service date is for 1-28-05.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 response,
Position Summary: None submitted.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
1-28-05	97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$618.40
		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

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.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues. Therefore, the amount due from the carrier for the medical necessity issue is \$618.40.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of \$618.40. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$650.00). 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 30 days of receipt of this Order.

Ordered by:

Dee Z Torres, Medical Dispute Officer

10-4-05

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.

September 28, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-3058-01
TWCC #:
Injured Employee:
Requestor: Jared Parker, OT
Respondent: Dallas ISD c/o Harris & Harris
MAXIMUS Case #: TW05-0181

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 physician occupational medicine 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 58-year old female who sustained a work related injury on _____. The patient reported that she was assaulted by a student while working as a teacher. She also reported that she sustained injury to her neck with a telephone during the assault. Diagnoses included cervical herniated disc, cervical sprain, pain disorder and anxiety disorder. Evaluation and treatment has included medical evaluation and follow-up evaluations, x-rays, MRI, functional capacity evaluation, rest, home exercise program, physical therapy, medical treatment, medication management and TENS unit.

Requested Services

Functional Capacity Evaluation on 1/28/05.

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

Documents Submitted by Requestor:

1. Letter of medical necessity – 7/6/05
2. Physician Records – 7/28/04-3/7/05
3. ROM History – 2/18/05-3/2/05
4. Functional Capacity Evaluation – 1/28/05
5. Evaluation by James E. Laughlin, DO – 2/24/05
6. TWCC Preauthorization Report & Notification Form – 2/16/05
7. Initial Diagnostic Screening – 1/28/05
8. Individual Psychotherapy Notes -2/16/05-3/7/05

Documents Submitted by Respondent:

1. None submitted

Decision

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

Rationale/Basis for Decision

MAXIMUS CHDR physician consultant indicated the member had chronic neck pain for several years. MAXIMUS CHDR physician consultant noted her prognosis was poor for improvement and she did not have any substantial gains despite medications, physical therapy, trigger point injections and psychotherapy services. MAXIMUS CHDR physician consultant explained that a functional capacity evaluation was ordered before physical therapy although some records reported she had physical therapy before initiating treatment. MAXIMUS CHDR physician consultant also indicated while it is more logical to perform a functional capacity evaluation before a work-hardening or work conditioning program, or in order to finalize a case, it was appropriate to make a final assessment of work capabilities at some point before the end of the member's care at the facility in question. MAXIMUS CHDR physician consultant noted that the member had a job to which she was returning and it was necessary to quantify her work abilities in a structured way.

Therefore, the MAXIMUS physician consultant concluded that the functional capacity evaluation on 1/28/05 was medically necessary for treatment of this patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department