



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 and Fee Dispute

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: <b>Rehab 2112 PO Box 671342 Dallas TX 75267-1342</b>	MDR Tracking No.: <b>M5-05-3175-01</b>
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: <b>Dallas Fire Insurance                      Box 20</b>	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position Summary: Services were medically necessary.

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package. Position Summary: All services in this matter have been denied both on compensability and medical necessity. As the injury has been found compensable at a hearing, the only issue in this matter is the medical necessity.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-5-04 to 8-25-04	97545-WH-CA (\$128.00 x 9 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,152.00
	97546-WH-CA (\$320.00 x 1 day)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$320.00
	97546-WH-CA (\$256.00 x 7 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,792.00
	97546-WH-CA (\$192.00 x 1 day)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$192.00
	97546-WH-CA (addtl quarter hrs) (20 x \$16.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$320.00
	97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$296.00
<b>TOTAL</b>			<b>\$4,072.00</b>

#### 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.

**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 \$4,072.00. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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:

Medical Dispute Officer

11-18-05

\_\_\_\_\_  
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.**

November 17, 2005

October 18, 2005

Texas Department of Insurance Division of Texas Workers Compensation  
MS48  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744-1609

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-05-3175-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Rehab 2112**  
**Respondent: Dallas Fire Insurance Company/Downs Stanford, PC**  
**MAXIMUS Case #: TW05-0201**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308 which allows for a dispute resolution by an IRO.

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 approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO, was signed. 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 a 30-pound object fell on him pinning him against a cement wall. He also reported that he lost consciousness for a few minutes. Diagnoses have included multiple left lateral costal fractures, left chest wall contusion, mechanical neck pain, cervical myositis. Evaluation and treatment have included CT scans, X-rays, chiropractic services, medication, work hardening and behavioral health services.

#### Requested Services

Work hardening – 97545-WH-CA, work hardening each additional hour – 97546-WH-CA and functional capacity exam – 97750-FC from 8/5/04-8/25/04.

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

##### *Documents Submitted by Requestor:*

1. MDR Request – 7/22/05
2. Letter of Medical Necessity – 7/11/05
3. Diagnostic Studies (X-rays, CT, MRIs) – 5/5/04, 5/10/04, 5/19/05, 5/21/04,
4. Orthopedic Consultation – 6/2/04
5. Rehab Daily Notes & Visit Log Reports – 6/18/04-8/25/04
6. Case Management Summaries – 7/14/04-8/25/04

7. Psychotherapy Notes – 7/11/04-8/11/04
8. Active Rehab Exercise Fee Slip and Exercises– 7/9/04
9. Work Program Participation Intake Sheet – 6/9/04
10. Comprehensive Patient Examination – 6/9/04
11. Recommended Treatment Plan – 6/9/04
12. Stress and Lifestyle Change Survey – 7/8/04
13. Functional Capacity Evaluations – 7/12/04, 8/3/04
14. Job Description - undated
15. Impairment Rating – 8/25/04
16. Visual Pain Rating Scale & Pain Diagram – 1/12/03
17. Chiropractic Records – 5/5/04-6/9/04

*Documents Submitted by Respondent:*

1. Letter of Dispute – 8/23/05
2. Physical Medicine & Rehabilitation Review of Medical Records – 8/4/04, 12/15/05

### **Decision**

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

### **Standard of Review**

This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.

### **Rationale/Basis for Decision**

The MAXIMUS chiropractor consultant indicated that the member met the American Physical Therapy Association (APTA) Guidelines for entrance into a work hardening program. The MAXIMUS chiropractor consultant explained that to be eligible for work hardening, a patient must have a targeted job plan to work with at the time of discharge, a patient must have identified physical, functional, behavioral and vocational deficits that interfere with work, and a patient must be at a point of resolution of the initial injury such that participation in the work hardening program would not be prohibited. The MAXIMUS chiropractor consultant noted that this patient's job target for the work hardening program was to be able to return to work at a medium heavy job that was the job category in which his job as a "crew member" was listing according to the dictionary of occupational titles. The MAXIMUS chiropractor consultant also indicated the patient performed a functional capacity evaluation on 8/3/04 which documented deficits in all cervical ranges of motion and a 50 pound average for dynamic lifting (his job requires 75 pounds regularly). The MAXIMUS chiropractor consultant noted the patient had completed both passive and an active treatment plan during the 13 weeks prior to the functional capacity evaluation that placed him in the secondary phase of care in which a multidisciplinary program such as work hardening is a possible intervention. The MAXIMUS chiropractor consultant indicated this patient met criteria for a work hardening program during the period in question.

Therefore, the MAXIMUS chiropractor consultant concluded that the work hardening – 97545-WH-CA, work hardening each additional hour – 97546-WH-CA and functional capacity exam – 97750-FC from 8/5/04-8/25/04 were medically necessary for treatment of the member's condition.

### **Your Right To Appeal**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department