



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:

Injury One Treatment Center  
5445 La Sierra Dr., Suite 204  
Dallas, Texas 75231

MDR Tracking No.: M5-06-1974-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Box 03

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

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

Position summary states, "It is our position that CMI has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to the injured worker. Your help in resolving this case is appreciated."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

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

Position summary states, "Based on a review of the adjuster's claim diary, a PLN-11 was reportedly filed on 5-13-05 disputing treatment and medications...In addition...the treatment rendered was determined to be unnecessary treatment for the patient. We will await IRO assignment."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

**PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services**

| Date(s) of Service | CPT Code(s) or Description       | Medically Necessary?  | Additional Amount Due (if any) |
|--------------------|----------------------------------|---|--------------------------------|
| 9-15-05            | 90801                            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$184.80                       |
| 9-26-05 – 10-13-05 | 97545-WH-CA (\$128.00 X 8 units) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$1,024.00                     |

|                    |                                  |   |            |
|--------------------|----------------------------------|---|------------|
| 9-26-05 – 10-13-05 | 97546-WH-CA (\$64.00 X 48 units) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$3,072.00 |
|                    | Total Due                        |   | \$4,280.80 |

**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 Position Statement from the Respondent states, "...a PLN-11 was reportedly filed disputing treatment and medications." However, the PLN 11 does not state that the current treatment is unrelated to the compensable injury. This injury is compensable.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did prevail on the disputed medical necessity issues. Per Rule 134.202(d)(2) the amount due the Requestor for the items denied for medical necessity is \$4,280.80.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202  
Texas Labor Code Sec. § 413.011(a-d), 413.031

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the carrier must refund the amount of the IRO fee (\$650.00) to the Requestor within 30 days of receipt of this order. The Division has determined that the Requestor is entitled to additional reimbursement in the amount of \$4,280.80. The Division hereby **ORDERS** the Respondent 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.

**Findings and Decision and Order by:**

|                               |                         |                        |
|-------------------------------|-------------------------|------------------------|
|                               | Medical Dispute Officer | 10-27-06               |
| _____<br>Authorized Signature | _____<br>Typed Name     | _____<br>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.**

October 16, 2006  
October 13, 2006

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

### AMENDED NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-06-1974-01**  
**DWC #: \_\_\_\_\_**  
**Injured Employee: \_\_\_\_\_**  
**Requestor: Injury One Treatment Center**  
**Respondent: CMI Barron**  
**MAXIMUS Case #: TW06-0133**

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 physician who is board certified in psychiatry 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 51-year old female who sustained a work related injury on \_\_\_\_\_. Records indicate that while working as a building attendant, she lifted a heavy bag of trash resulting in immediate pain in the mid-thoracic area and later increasing pain across her back. Diagnoses have included thoraco-lumbar strain and upper thoracic myofascial back pain. Evaluation and treatment for this injury have included medications, physical therapy, injections and chiropractic therapy.

## Requested Services

Work hardening for 9/26/05-10/13/05 and 90801-Psych Interview for 9/15/06.

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

### *Documents Submitted by Requestor:*

1. J. Scott Crockett, DO Records and Correspondence – 9/20/06
2. Injury 1 Treatment Center Records – 9/15/05-12/29/05

### *Documents Submitted by Respondent:*

1. Carrier's Position Statement – 9/7/06
2. Employer's First Report of Injury – 8/28/04
3. Don Mackey, MD Records – 10/4/04
4. Hewitt W. Ratliff, MD Records and Correspondence – 4/4/05
5. Howard T. Douglas, MD Records and Correspondence – 4/27/05
6. J. Scott Crockett, DO Records and Correspondence – 9/14/05, 9/21/05,
7. Injury 1 Treatment Center Records – 9/15/05-12/2/05

## Decision

The Carrier's denial of authorization for the work hardening for 9/26/05-10/13/05 and 90801-Psych Interview for 9/15/06 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 the patient had a work related thoraco-lumbar strain/sprain with continuous back pain, unrelated poor general physical fitness and degenerative changes. The MAXIMUS chiropractor consultant noted he has failed to respond to many appropriate supportive and psychological approaches to reduce his pain and increasing life restrictions. The MAXIMUS chiropractor consultant also noted that the work hardening was medically necessary for its practical, goal oriented cognitive behavioral, supportive and structured efforts to assist her to deal more effectively with her overall problem of pain and a possible return to fitness and better management of her disability as it related to work tasks. The MAXIMUS chiropractor consultant explained that the presence of co-morbid and unrelated degenerative changes in no way is relevant to the issue of potential benefit psychologically for this patient who wishes to function better.

Therefore, the MAXIMUS physician consultant concluded that the work hardening for 9/26/05-10/13/05 and 90801-Psych Interview were medically necessary for treatment of the member's condition.

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Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department