

June 7, 2006

VIA FACSIMILE

Transcontinental Insurance Company/Transportation Insurance

Attention: Jane Stone

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-06-1235-01

DWC #:

Injured Employee: ____

Requestor: ____

Respondent: Transcontinental Insurance Company/Transportation Insurance

MAXIMUS Case #: TW06-0087

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 physical medicine and rehabilitation 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 an adult male who had a work related injury on _____. The patient sustained a complete spinal cord injury when his airplane crashed while trying to avoid hitting another plane at an air show. Review of the case file records noted that his tracheostomy was closed in June 2004 and that he only used a ventilator at night. These records explained that he experiences difficulty managing his secretions and also develops neck and shoulder girdle pain. Diagnoses included quadriplegia (C1-C4), autonomic dysreflexia, hypotension, and edema. Evaluation and treatment have included 24 hours per day nursing care, therapy, and medications.

Requested Services

Preauthorization for occupational therapy 3XWK X 12 months.

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

Documents Submitted by Requestor:

1. Letter of Appeal – 4/12/06
2. Concerta Precertification Request – not dated
3. Advanced Therapy Services of Dallas Records – 2/29/06
4. Determination Notices – 3/6/06, 3/20/06

Documents Submitted by Respondent:

1. Response to Request for Records – 5/10/06
2. Determination Notices – 3/6/06, 3/20/06
3. Required Medical Evaluation – 4/1/05
4. Advanced Therapy Services of Dallas Records – 2/29/06
5. Reachout Home Care Records & Correspondence – 8/1/05-3/13/06

Decision

The Carrier's denial of authorization for the requested services is partially 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 physician consultant indicated the patient is a 63-year old male with a complete spinal cord injury as a result of a work related accident since _____. The MAXIMUS physician consultant also noted he currently has 24 hour per day nursing care. The MAXIMUS physician consultant indicated he received occupational therapy services 3 times per week for range of motion and stretching of tight muscles until 4/1/05. The MAXIMUS physician consultant noted that an occupational therapy evaluation was performed on 2/10/06 that reported the member had increased tightness of the hamstrings, shoulders and neck, and pain at the base of the shoulder and upper neck limiting his only active motion. The MAXIMUS physician consultant explained that the goals of occupational therapy were to reduce hamstring tightening, increase range of motion by 7%, decrease pain in neck by 20% and decrease edema in all extremities by 7%. The MAXIMUS physician consultant also indicated that occupational therapy 3 times per week for 12 months is not medically indicated as there is no expectation of significant improvement in a reasonable period of time projected. The MAXIMUS physician consultant noted that the patient has a chronic condition and his projected gains over a 12-month period appear minor. The MAXIMUS physician consultant also noted that occupational therapy 3 times

per week for 4 weeks is sufficient to establish a home exercise program and to train the caregivers to continue the range of motion and manage treatments.

Therefore, the MAXIMUS physician consultant concluded that the requested preauthorization for occupational therapy 3 X WK for 4 weeks is medically necessary for treatment of the member's condition. The MAXIMUS physician consultant concluded that the requested preauthorization for occupational therapy 3 X WK for more than 4 weeks is not 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

cc: Division of Workers Compensation

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 7th day of June 2006.

Signature of IRO Employee: _____
External Appeals Department