

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on April 26, 2004.

Based on correspondence from the requestor, Health & Medical Practice, dated, 11-18-04, all fee issues in dispute have been withdrawn therefore, will not be addressed in this review.

The only issues in dispute are for medical necessity and therefore, will be addressed by an IRO.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The ultrasound, therapeutic exercises/activities, NCV (sensory), chiropractic manipulation, electrical stimulation, massage therapy, and office visits denied with U and/or V from 07-16-03 through 11-11-03 **were found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision is hereby issued this        day of January 2005.

Medical Dispute Resolution Officer  
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 07-16-03 through 11-11-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this \_\_\_\_\_ day of January 2005.

Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/pr

Enclosure: IRO decision

MAXIMUS

September 10, 2004  
Texas Workers Compensation Commission  
MS48  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744-1609

**NOTICE OF INDEPENDENT REVIEW DECISION  
Amended Letter**

**RE: MDR Tracking #: M5-04-2692-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Health & Medical Practice**  
**Respondent: University of Texas System**  
**MAXIMUS Case #: TW04-0254**

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 chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor 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 chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

### **Clinical History**

This case concerns a 25 year-old female who sustained a work related injury on 6/\_\_\_/03. The patient reported that while at work she injured her left elbow when she attempted to lift a stack of books. A MRI of the left elbow performed on 7/21/03 indicated no evidence of ligament, tendon, nor muscular or osseous injury of the left elbow, no evidence for biceps tendon tear or injury, and minimal linear inflammation deep to the common flexor tendon, compatible with minimal peritendinitis. The diagnoses for this patient's condition have included left forearm sprain/strain and left forearm myofascial pain. Treatment for this patient's condition has included ultrasound, hot/cold packs, and electrical stimulation.

### **Requested Services**

**Ultrasound, therapeutic exercises/activities, NCV (sensory), chiropractic manipulation, electrical stimulation, massage therapy, and office visits from 7/16/03 through 11/11/03.**

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

*Documents Submitted by Requestor:*

1. No documents submitted

*Documents Submitted by Respondent:*

2. Response to IRO request 6/10/04
3. MRI report 7/21/03
4. Initial evaluation 6/27/03
5. FCE 7/14/03, 10/09/03, 11/11/03
6. Medical Record Review 1/16/04

### **Decision**

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

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

**The MAXIMUS chiropractor reviewer noted that this case concerns a 25 year-old female who sustained a work related injury to her left elbow on 6/21/03. The MAXIMUS chiropractor reviewer also noted that the diagnoses for this patient have included left forearm sprain/strain and left forearm myofascial pain. The MAXIMUS chiropractor reviewer further noted that the treatment for this patient's condition has included ultrasound, hot/cold packs, and electrical stimulation. The MAXIMUS physician reviewer explained that this patient's response to treatment was slow. The MAXIMUS chiropractor reviewer also explained that although the patient failed to respond well to the treatment rendered, the treatment was appropriate and medically necessary. Therefore, the MAXIMUS chiropractor consultant concluded that the ultrasound, therapeutic exercises/activities, NCV (sensory), chiropractic manipulation, electrical stimulation, massage therapy, and office visits from 7/16/03 through 11/11/03 were medically necessary to treat this patient's condition.**

Sincerely,  
MAXIMUS

Elizabeth McDonald  
State Appeals Department



**TEXAS**  
**WORKERS' COMPENSATION COMMISSION**  
7551 Metro Center Drive, Suite #100, Austin, Texas 78744  
(512) 804-4800

**MEMORANDUM**

**DATE:**        \_\_\_/\_\_\_/ 2005

**TO:**           Austin Commission Representative, Box # 46

**CARRIER:**   The University of TX System

**FROM:**        Medical Review Division

**RE:**           **NOTICE of Independent Review Organization and  
Medical Dispute Resolution DECISION & ORDER**

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**This memorandum shall serve as your notice to present yourself to the Mail Room Service Counter:**

(X)            An IRO and MDR Decision & Order.

The above referenced document has been issued in a medical dispute case review pertaining to the following claimant and insurance carrier:

**IDENTIFIER**

**MDR TRACKING #: M5-04-2692-01**  
**TWCC FILE #: X2636818**  
**CLAIMANT: Blanca A. Salinas**  
**DOI: 06-21-03**  
**SSN: 452-63-2977**

I, the undersigned Representative of the above referenced insurance carrier, do hereby acknowledge receipt of the IRO and MDR Decision & Order applicable to a medical dispute resolution request solicited by the requestor.

Receipt of this Decision & Order is hereby acknowledged this \_\_\_ day of \_\_\_\_\_ 2005.

Signature of Commission Representative: \_\_\_\_\_

Printed Name of Commission Representative: \_\_\_\_\_