

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 June 1, 2004.

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 \$650.00** 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 not the only issue** to be resolved. The therapeutic procedure, massage, office visits, electrical stimulation, and gait training from 1/23/04 through 2/16/04 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On August 13, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR	Rationale
1/26/04	99212	\$32.00	\$28.80	C	\$44.17	Review of the requestor's position statement revealed that requestor does not have a contract with the carrier. The carrier has not submitted relevant information to support their denial code of "C". In accordance with the TWCC Rule 134.202 (d)(1), the requestor is therefore entitled to additional reimbursement in the amount of \$3.20.
1/26/04 1/27/04 1/28/04 2/2/04 2/3/04 2/6/04	97032	\$18.83 x 6 = \$112.98	\$16.85 x 6 = \$101.10	C	\$18.73 x 6 = \$112.38	Review of the requestor's position statement revealed that requestor does not have a contract with the carrier. The carrier has not submitted relevant information to support their denial code of "C". In accordance with the TWCC Rule 134.202 (d)(1), the requestor is therefore entitled to additional reimbursement in the amount of \$11.28.

1/26/04 1/27/04 1/28/04 2/2/04 2/3/04 2/6/04	97124	\$25.70 x 6 = \$154.20	\$23.13 x 6 = \$137.78	C	\$26.28 x 6 = \$157.68	Review of the requestor's position statement revealed that requestor does not have a contract with the carrier. The carrier has not submitted relevant information to support their denial code of "C". In accordance with the TWCC Rule 134.202 (d)(1), the requestor is therefore entitled to additional reimbursement in the amount of \$19.90.
1/26/04 1/27/04 1/28/04 2/2/04 2/3/04 2/6/04	97116	\$34.63 x 6 = \$207.78	\$26.55 x 6 = \$159.30	C	\$29.50 x 6 = \$177.00	Review of the requestor's position statement revealed that requestor does not have a contract with the carrier. The carrier has not submitted relevant information to support their denial code of "C". In accordance with the TWCC Rule 134.202 (d)(1), the requestor is therefore entitled to additional reimbursement in the amount of \$17.70.
TOTAL			\$0.00			Reimbursement is recommended in the amount of \$52.08.

ORDER

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) 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 1/23/04 through 2/16/04 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 31st day of January 2005.

Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

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 #: M5-04-3333-01
TWCC #:
Injured Employee:
Requestor: S.A. Accident/Injury Care
Respondent: Texas Mutual Insurance Company
MAXIMUS Case #: TW04-0331

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 anesthesiology 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 female who sustained a work related injury on 10/__/03. The patient reported that while at work she injured her right knee. A MRI of the right knee performed on 12/11/03 indicated a moderate sized joint effusion, degenerative chondromalacia involving the weight bearing portion of the lateral tibial plateau, and degenerative chondromalacia involving the weight bearing portion of the medial femoral condyle. The diagnoses for this patient have included internal derangement of the right knee, acute, moderated, chondromalacia of the right patella, acute, moderate, and inflammation of the right knee, acute, moderate. Treatment for this patient's condition has included electrical stimulation, massage, ultrasound, stretches and bike exercises to the right knee to reduce swelling, inflammation and pain and to increase mobility.

Requested Services

97150, 99212, 97032, 97124, 97116, and 97032 from 1/26/04 through 2/16/04.

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

Documents Submitted by Requestor:

1. Workers Compensation Initial Evaluation Report 1/26/04
2. Office notes 1/26/04 – 2/16/04
3. Training Log
4. FCE 3/23/04
5. MRI report 12/11/03
6. Orthopedic notes 2/5/04 – 3/25/04

Documents Submitted by Respondent:

1. No documents submitted

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 physician reviewer noted that this case concerns a 40 year-old female who sustained a work related injury to her right knee on 10/23/03. The MAXIMUS physician reviewer indicated that the patient had pain, decreased range of motion in the right ankle and decreased strength in the right quadriceps. The MAXIMUS physician reviewer noted that the initial treatment for this patient's condition was conservative care followed by physical therapy that included electrical stimulation, massage, gait training, and exercises. The MAXIMUS physician reviewer explained that by 2/11/04 the patient's pain had reduced from a 7/10 to a 5/10. The MAXIMUS physician reviewer also explained that the patient had shown improvement and benefit from the therapy intervention. Therefore, the MAXIMUS physician consultant concluded that the 97150, 99212, 97032, 97124, 97116, and 97032 from 1/26/04 through 2/16/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department