

MDR Tracking Number: M5-05-0620-01

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, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-25-04.

The IRO manual therapy, therapeutic exercises and ultrasound rendered from 02-24-04 through 03-18-04 that were denied based upon U”.

The IRO determined that 1 unit of manual therapy per visit and the ultrasound therapy from 03-09-04 through 03-18-04 **were** medically necessary. The IRO further determined that the therapeutic exercises and remaining units of manual therapy from 03-09-04 through 03-18-04 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-12-04, 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.

HCPCS code E0720 date of service 03-18-04 denied with denial code “M” (No MAR). The requestor submitted documentation to support the services billed. The carrier has made a payment of \$43.72. Additional payment in the amount of \$81.28 is recommended.

### **ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c), plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 02-25-04 through 03-18-04 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 Findings and Decision and Order are hereby issued this 31st day of December 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

December 30, 2004

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

#### **NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-05-0620-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Valley Spine Medical Center**  
**Respondent: Texas Mutual Insurance Company**  
**MAXIMUS Case #: TW04-0493**

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 male who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work he injured his right knee when he slipped and fell landing on his right knee. The initial diagnoses for this patient included right knee sprain/strain, rule out torn meniscus, and sprain/strain ACL. The patient underwent an MRI of the right knee on 1/22/04 that revealed a small amount of joint fluid, minimal popliteal cyst along the posteromedial aspect of the knee, evidence of sprain and partial thickness tear involving the inferior portion of the anterior cruciate ligament, and no medial or lateral meniscal tear. On 2/16/04 the patient underwent diagnostic and operative arthroscopy of the right knee for the preoperative diagnoses of rule out torn medial meniscus. The postoperative diagnoses included rule out torn medial meniscus, normal menisci, normal anterior cruciate ligament and normal scope. Postoperatively the patient was treated with postoperative therapy.

## Requested Services

Manual therapy, therapeutic exercises and ultrasound from 2/24/04 through 3/18/04.

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

### *Documents Submitted by Requestor:*

1. Initial Medical Narrative Report 5/8/03
2. MRI report 1/22/04
3. Operative Report 2/16/04
4. Therapeutic Procedure Chart 2/24/04 – 3/18/04
5. Progress Notes 2/24/04 – 3/18/04

### *Documents Submitted by Respondent:*

1. No Documents Submitted

## Decision

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

## Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his right knee on \_\_\_\_\_. The MAXIMUS chiropractor reviewer indicated that the patient underwent a scoping of the right knee that was reported as normal. The MAXIMUS chiropractor reviewer explained that the recovery following the patient's surgery should have been short and without complications because there were no procedures performed during the scoping itself. The MAXIMUS chiropractor reviewer indicated that 2-4 weeks of mild physical therapy (45 minutes) and ultrasound daily after the scoping would be appropriate to attain the therapeutic results required. The MAXIMUS chiropractor reviewer explained that the documentation provided does not support the need for 5-6 units of one on one therapy. Therefore, the MAXIMUS chiropractor consultant concluded that 1 unit of manual therapy (97140) per visit and the ultrasound (97035) from 3/9/04 through 3/18/04 were medically necessary to treat this patient's condition. The MAXIMUS chiropractor consultant

further concluded that the therapeutic exercises (97110), and remaining units of manual therapy (97140) from 3/9/04 through 3/18/04 were not medically necessary to treat this patient's condition.

Sincerely,  
**MAXIMUS**

Elizabeth McDonald  
State Appeals Department