

MDR Tracking Number: M5-05-1432-01

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 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. The dispute was received on 1-13-05.

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 office visits-level III, therapeutic exercises and manual therapy technique from 6-2-04 through 8-27-04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

**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 for outlined above as follows:**

- 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 Order is applicable to dates of service 6-2-04 and 8-27-04 as outlined above 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 11th day of March 2005.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da

Enclosure: IRO decision

March 9, 2005

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

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

**RE: MDR Tracking #: M5-05-1432-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Michael Combs, D.C.**  
**Respondent: SORM**  
**MAXIMUS Case #: TW05-0021**

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 female who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work she injured her back when she was moving boxes during an office move. An MRI performed on 10/18/02 indicated a 1-2 mm annular bulge at L3-L4 and a L5-S1 1-2mm disc bulge. On 4/14/03 the patient underwent an EMG/NCV that showed bilateral L5-S1 radiculopathy, right greater than left. The diagnoses for this patient have included L5-S1 radiculopathy, L5-S1 and L3-L4 disc bulges, bilateral sacroiliac dysfunction, and resolved lumbosacral sprain/strain. Treatment for this patient's condition has included conservative therapy, and one epidural steroid injection.

### Requested Services

Office visit level III, therapeutic exercises, manual therapy technique from 6/2/04 through 8/27/04.

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

#### *Documents Submitted by Requestor:*

1. Letter from Requestor 2/4/05
2. Treatment Records 8/27/04 and 2/13/04
3. Letter to SORM 11/5/04

#### *Documents Submitted by Respondent:*

1. Impairment Rating 10/6/03
2. Treatment Records 9/23/02 - 7/30/03
3. EMG/NCV report 4/14/03
4. IRE Exam report 3/14/03

### Decision

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

### Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her back on \_\_\_\_\_. The MAXIMUS chiropractor reviewer indicated that the patient was treated conservatively with marked improvement but no complete resolution. The MAXIMUS chiropractor reviewer noted that the patient was left with a 10% whole person impairment rating and released from active care with orders to return on an as needed basis. The MAXIMUS chiropractor reviewer indicated that the patient had periodical exacerbations and that the patient responded well to treatment. The MAXIMUS chiropractor reviewer explained that the type of treatment rendered to this patient is warranted although the patient had reached maximum medical improvement with a permanent impairment. The MAXIMUS chiropractor reviewer indicated that TWCC guidelines allow for supportive care to reduce pain after the patient had met maximum medical improvement. The MAXIMUS chiropractor reviewer explained that the follow up care this patient had received was medically appropriate. The MAXIMUS chiropractor reviewer also explained that the treatment this patient received was well documented and substantiated for the periodic medically necessary care this patient required. Therefore, the MAXIMUS chiropractor consultant concluded that the office visit level III, therapeutic exercises, manual therapy technique from 6/2/04 through 8/27/04 were medically necessary to treat this patient's condition.

Sincerely,  
**MAXIMUS**

Elizabeth McDonald  
State Appeals Department