

MDR Tracking Number: M5-05-1574-01

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 1-31-05.

A Benefit Review Conference on 11-17-04 determined that these services were compensable.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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.

CPT code 98943 was reviewed by the IRO. This code is not reimbursable according to the Medicare program reimbursement methodologies.

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

Chiropractic manipulation, therapeutic exercises, electrical stimulation, ultrasound, manual therapy technique and neuromuscular reeducation, from 2-18-04 through 5-10-04 **were found** to be medically necessary. Chiropractic manipulation, therapeutic exercises, electrical stimulation, ultrasound, manual therapy technique, neuromuscular reeducation, phone call and office visit from 5-13-04 through 8-3-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount due the requestor for the medical necessity issues is \$2,462.69.

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 totaling \$2,462.69 from 2-18-04 through 5-10-04 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 hereby issued this 21st day of April 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

April 19, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-1574-01
TWCC #:
Injured Employee:
Requestor: All Star Chiropractic & Rehab
Respondent: St. Paul Fire & Marine Ins.
MAXIMUS Case #: TW05-0063

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 46 year-old male who sustained a work related injury on _____. The patient reported that while at work he injured his knee when he was climbing the tower to the cab of his crane. The patient underwent a previous MRI examination of his right knee in 5/2003 and a repeat MRI on 1/20/04 after the work related injury. On 2/8/05 the patient underwent a third MRI of the right knee that revealed evidence of a partial medial meniscectomy, full thickness tear of the anterior cruciate ligament, focal area of chondromalacia of the femoral trochlea centrally, mild degenerative arthrosis of both medial and lateral femorotibial compartments with mild diffuse chondromalacia of the medial femoral condyle, and a small tear of the lateral meniscus

at its anterolateral corner extending into the inferior articular surface. Initial treatment was conducted by a chiropractor. The patient changed treating physicians and has been treated with chiropractic manipulation, therapeutic exercises, electrical stimulation, ultrasound, manual therapy technique, and neuromuscular reeducation.

Requested Services

Chiropractic manipulation, therapeutic exercises, electrical stimulation, ultrasound, manual therapy technique, neuromuscular reeducation, phone call, office visit from 2/18/04 through 8/3/04.

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

Documents Submitted by Requestor:

1. Initial Functional Capacity Evaluation 1/31/05
2. Progress Report 2/18/04 - 1/26/05
3. Initial Consultation 1/14/04
4. MRI report 2/8/05
5. Initial Consultation and Progress Reports 8/18/04 – 11/17/04

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 knee on _____. The MAXIMUS chiropractor reviewer indicated that this patient's work related injury required surgical intervention. The MAXIMUS chiropractor reviewer explained that a trial of conservative treatment 3 times a week for 6-8 weeks was medically appropriate. The MAXIMUS chiropractor reviewer indicated that without documented improvement in the patient's condition continued treatment was not medically necessary. The MAXIMUS chiropractor reviewer explained that after 24 visits this patient failed to demonstrate any objective or subjective improvement. The MAXIMUS chiropractor reviewer noted that the patient's treatment continued for an additional 4 months without change in the patient's condition or change in the treatment plan. The MAXIMUS chiropractor reviewer explained that the treatment this patient received was not relieving his pain, curing his condition, or facilitating him to return to work. Therefore, the MAXIMUS chiropractor consultant concluded that the chiropractic manipulation, therapeutic exercises, electrical stimulation, ultrasound, manual therapy technique, neuromuscular reeducation from 2/18/04 through 5/10/04 were medically necessary to treat this patient's condition.

The MAXIMUS chiropractor consultant further determined that the chiropractic manipulation, therapeutic exercises, electrical stimulation, ultrasound, manual therapy technique, neuromuscular reeducation, phone call, office visit from 5/13/04 through 8/3/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department