

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION**Retrospective Medical Necessity Dispute****PART I: GENERAL INFORMATION**

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestors Name and Address Pain & Recovery c/o Bose Consulting LLC PO Box 550496 Houston TX 77255	MDR Tracking No.: M5-05-2275-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Box 17 Benchmark Ins/Covenant 1420 W. Mockingbird Lane #775 Dallas TX 75247	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
5-13-04	10-1-04	99212, 99214, 97032, 97035, 97110, 97112, and E1399	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues.

The carrier submitted proof of payment for services rendered 5-13-04 and 6-30-04; therefore, these dates of service are no longer in dispute.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus \$8,193.73 for the medical necessity issues in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20 days of receipt of this Order.

Ordered by:

7-8-05

Authorized Signature_____
Date of Order

Findings & Decision by:

7-8-05

Authorized Signature

Date of Decision

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and the TWCC Chief Clerk of Proceedings/Appeals Clerk must receive it within 20 days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representative's box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

July 7, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION – Corrected Letter

RE: MDR Tracking #: M5-05-2275-01
TWCC #: _____
Injured Employee: _____
Requestor: Pain & Recovery c/o Bose Consulting, LLC
Respondent: Bench Ins./Covenant
MAXIMUS Case #: TW05-0101

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 31 year-old male who sustained a work related injury on _____, when he slipped and sprained his right ankle. A MRI of his right ankle performed on 11/12/03 showed bone marrow changes of the talus consistent with a bone marrow bruise, severe strain of the lateral collateral ligaments of the ankle with a suspected partial tear, joint effusion and soft tissue swelling and indicated that a small incomplete fracture could be present. On 2/20/04, the patient underwent a right ankle arthroscopy, lateral ligament repair via calcaneal fibula as well as ATF ligament primarily right, drilling via an arthrotomy of the ankle joint of osteochondral lesion of the talus. Postoperative diagnoses from this procedure included torn ATF and calcaneal fibular ligaments, osteochondral lesions, internal ankle derangement and ankle instability. The patient reported that he reinjured his ankle on _____ during a functional capacity examination. Treatment for the patient's condition has included use of a customized

brace, physical therapy, chiropractic therapy, work hardening, a TENS unit, massage therapy, over the counter nonsteroidal anti-inflammatory medications and prescription medications. Diagnoses for this patient included other postsurgical status.

Requested Services

CPT Codes 99212, 99214 office visits, established patient, 97032 electrical stimulation (manual), 97035 ultrasound, 97110 therapeutic exercises, 97112 neuromuscular re-education, and E1399 DME from 5/13/04 to 10/1/04.

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

Documents Submitted by Requestor:

1. None submitted

Documents Submitted by Respondent:

1. Peer review report dated 4/30/05
2. Designated Doctor Evaluation report dated 4/5/04
3. Impairment Evaluation report dated 1/22/04
4. Operative report dated 2/20/04
5. Office visit notes from the patient's podiatrist dated 3/8/04, 6/1/04
6. Retrospective Peer Review Report dated 6/21/04
7. Current Review Report dated 2/18/04

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 31 year-old male who sustained a work related injury to his right ankle on _____. The MAXIMUS chiropractor reviewer also noted that the patient underwent right ankle surgery on 2/20/04. The MAXIMUS chiropractor reviewer further explained that the information provided in the case file demonstrates that this patient responded well to the treatment at issue. The MAXIMUS chiropractor reviewer indicated that an office note dated 8/26/04 reported that the member was 90% better, back to light duty work and considering going back to work full time. The MAXIMUS chiropractor reviewer also indicated that continued treatment through 10/1/04 was appropriate.

Therefore, the MAXIMUS physician consultant concluded that the CPT Codes 99212, 99214 office visits, established patient, 97032 electrical stimulation (manual), 97035 ultrasound, 97110 therapeutic exercises, 97112 neuromuscular re-education, and E1399 DME from 5/13/04 to 10/1/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Lisa K. Maguire, Esq.
Project Manager, State Appeals