

## 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
Requestor's Name and Address  Cotton D. Merritt DC 2005 Broadway Lubbock TX 79401	MDR Tracking No.: M5-05-2424-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Box 54  Texas Mutual Ins 221 W. 6 <sup>th</sup> St Ste 300 Austin TX 78701	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		
6-1-04	1-14-05	99212-25, 97110, 97112, 97140	<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.

#### 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 and \$10,400.75 for the services 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:

Authorized Signature	Typed Name	7-6-05 Date of Order
Findings & Decision by:		
Authorized Signature	Typed Name	7-6-05 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 in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

June 24, 2005

**MAXIMUS<sup>®</sup>**  
HELPING GOVERNMENT SERVE THE PEOPLE

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

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

**RE: MDR Tracking #: M5-05-2424-01**  
**TWCC #: \_\_\_\_\_**  
**Injured Employee: \_\_\_\_\_**  
**Requestor: Cotton Merritt, DC**  
**Respondent: Texas Mutual Insurance Company**  
**MAXIMUS Case #: TW05-0114**

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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This chiropractor is a chiropractor and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating chiropractors or providers or any of the chiropractors 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 56-year old female who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work she had a bar hit her on the front of both proximal tibias. A diagnosis of meniscus tear was made and surgery was performed on 3/2/04. She subsequently underwent total knee replacement surgery on 9/8/04. Treatment for this patient's condition consisted of therapeutic exercises, neuromuscular re-education and manual therapy technique.

### **Requested Services**

99212-25 office visits, chiropractic therapeutic exercises, 97112 neuromuscular re-education and 97140 manual therapy technique from 6/1/04-1/14/05.

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

*Documents Submitted by Requestor:*

1. Request for Reconsideration 5/13/05

*Documents Submitted by Respondent:*

1. MRI left knee 2/4/04-
2. Occupational therapy records 1/14/04-5/14/04
3. Operative report 3/2/04
4. Sports Medicine evaluation 6/7/04
5. Electrodiagnostic testing 6/10/04
6. Chiropractic evaluation and follow-up visits 5/27/04-2/17/05

**Decision**

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

**Rationale/Basis for Decision**

The MAXIMUS chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her knee on \_\_\_\_\_. The MAXIMUS chiropractor reviewer indicated that given the extent of the patient's injury that led to surgery, the preoperative and postoperative treatment was medically necessary for treatment of his condition. The MAXIMUS chiropractor reviewer noted that the patient responded slowly, but favorably to treatment. The MAXIMUS chiropractor reviewer also indicated the office visits, chiropractic therapeutic exercises, neuromuscular re-education and manual therapy technique from 6/1/04-1/14/05 were medically necessary for treatment of this patient's condition.

Therefore, the MAXIMUS chiropractor consultant concluded that 99212-25 office visits, chiropractic therapeutic exercises, 97112 neuromuscular re-education and 97140 manual therapy technique from 6/1/04-1/14/05 were medically necessary to treat this patient's condition.

Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department