



Texas Department of Insurance, Division of Workers' Compensation
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION
Retrospective Medical Necessity

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Pain & Recovery Clinic c/o Bose Consulting LLC PO Box 550496 Houston TX 77255	MDR Tracking No.: M5-05-2763-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Insurance Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC 60 package and EOBs. Position summary: The requestor submitted background information, nature of service in dispute, treatment provided has been reasonable and necessary, inappropriate audit by the carrier and conclusion which states, "...The above indicates that the treatment provided for the claimant was medically reasonable and necessary. We are requesting reimbursement for all disputed dates of services."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 response and EOBs. Position summary: Carrier states they will pay for code 99080 for dates of service 8-6-04 and 8-9-04 and questioned the product/service billed with E1399 on several dates of service.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due (if any)
7-28-04 to 9-2-04	99212, 97032, 97140, 97110, 97112, 99214, and E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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 did not prevail on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.202, 133.308

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the parties are instructed to review the IRO decision and take appropriate action. The requestor is not entitled to a refund of the IRO fee.

Findings and Decision

Dee Z Torres, Medical Dispute Officer

9-28-05

Authorized Signature

Typed Name

Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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

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September 21, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-2763-01
TWCC #: _____
Injured Employee: _____
Requestor: Pain & Recovery Clinic c/o Bose Consulting LLC
Respondent: Liberty Mutual c/o Hammerman & Gainer
MAXIMUS Case #: TW05-0156

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 _____. He complained of bilateral knee pain. He was treated with surgery, oral medications, therapeutic exercises, manual therapy tech, neuromuscular re-education and electrical stimulation from 7/28/04-9/2/04.

Requested Services

Office visits, electrical stimulation, manual therapy techniques, therapeutic exercises, neuromuscular re-education and miscellaneous DME from 7/28/04-9/2/04.

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

Documents Submitted by Requestor:

Daily Progress Notes – 7/28/04-9/2/04

Documents Submitted by Respondent:

1. Operative Report – 6/3/04
2. Preliminary Chiropractic Modality Review – 8/31/04
3. Pain & Recovery Clinic of Houston-SW Daily Progress Note – 7/28/04-8/25/04
4. Pain & Recovery Subsequent Medical Report – 7/30/04

Decision

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

Rationale/Basis for Decision

MAXIMUS chiropractor consultant indicated that according to the records, the patient injured his knees on 9/22/05. MAXIMUS chiropractor consultant noted the patient had a medial meniscectomy to the left knee on 6/3/04. MAXIMUS chiropractor consultant explained that the patient started post-operative rehabilitation to the left knee on 6/14/04. MAXIMUS chiropractor consultant also indicated that according to the 2004 Official Disability Guidelines, the appropriate rehabilitation after a meniscectomy is 8 weeks. MAXIMUS chiropractor consultant noted there is no evidence in the records, and in particular the re-evaluation dated 7/30/04, such as range of motion or strength measurements, that would justify the additional treatment from 7/28/04-9/2/04.

Therefore, the MAXIMUS physician consultant concluded that the office visits, electrical stimulation, manual therapy techniques, therapeutic exercises, neuromuscular re-education and miscellaneous DME from 7/28/04-9/2/04 were not medically necessary for treatment of this patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department