



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  <b>Richard Stephenson DC</b> <b>322 North Main St</b> <b>Bryan TX 77803</b>	MDR Tracking No.: M5-06-0052-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:  <b>Box 45</b>	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package, EOBs, CMS-1500s. Position Summary: The treatment during [this period] consisting of chiropractic management is in accordance with the TWCC Spine Guidelines and the Medicare guidelines.

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 response. Position Summary: The Office will maintain its denial for all other dates of service for ANSI code 50.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
1-24-05 to 3-31-05	99213 (\$50.00 x 6 days = \$300.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$300.00
	97035 (\$14.63 x 3 days = \$ 43.89)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$ 43.89

#### 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 **prevailed** on the disputed medical necessity issues.

Based on review of the disputed issues within the request, Medical Review has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 11-14-05, the requestor submitted a letter of withdrawal for code 99455-VR. The carrier reimbursed the additional \$188.11. Therefore, no dispute exists.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.202

**PART VII: DIVISION DECISION AND ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of \$343.89.

In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Ordered by:

Medical Dispute Officer

11-18-05

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date of Order

**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.**

November 14, 2005  
October 26, 2005

Ms. \_\_\_\_  
Texas Department of Insurance Division of Texas Worker's Compensation  
MS48  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744-1609

### Amended NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-06-0052-01  
DWC #:  
Injured Employee:  
Requestor: Richard Stephenson, DC  
Respondent:  
MAXIMUS Case #: TW05-0206

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308 which allows for a dispute resolution by an IRO.

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 condition and treatment options at issue in this appeal. The reviewer has met the requirements for the approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO, was signed. In addition, the MAXIMUS physician 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 she caught her left boot on a door jam causing it to be pulled backward while she was walking through it. She also reported that she did not fall, but noticed a twinge of pain to the left knee. She was diagnosed with a medial meniscal tear of the left knee. Evaluation and treatment have included surgery, chiropractic management and adjunctive therapy modalities.

#### Requested Services

99213-office visits, 97035-ultrasound from 1/24/05-3/31/05.

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

##### *Documents Submitted by Requestor:*

1. Operative Report – 1/7/05
2. Orthopedic Evaluations – 11/19/04, 1/14/05
3. MRI – 11/8/04
4. Chiropractic Records - 11/4/04-3/29/05
5. Functional Capacity Test – 11/29/04

*Documents Submitted by Respondent:*

1. Diagnostics Studies (MRI, x-rays) – 9/28/04-11/8/04
2. Consultations, Progress Notes – 9/28/04-3/31/05
3. Operative Report – 1/7/05

Decision

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

Standard of Review

**This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.**

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted the patient had a medial meniscal tear that required surgical repair. The MAXIMUS chiropractor reviewer indicated to enhance recovery and promote healing and a return to work, postoperative therapy was medically necessary. The MAXIMUS chiropractor reviewer noted the patient's care was provided and documented a steady decrease in pain and increased function. The MAXIMUS chiropractor reviewer explained that she ultimately was cleared to return to work on 3/31/05. The MAXIMUS chiropractor reviewer indicated the care given was prescribed by the surgeon and provided by the patient's chiropractor. The MAXIMUS chiropractor reviewer also noted the office visits and ultrasound treatment from 1/24/05-3/31/05 was within accepted standards of care post operatively and therefore medically necessary for the patient's condition.

Therefore, the MAXIMUS chiropractor consultant concluded that the 99213-office visits, 97035-ultrasound from 1/24/05-3/31/05 were medically necessary for treatment of this patient's condition.

**Your Right To Appeal**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department