

February 7, 2005

Ms. Courtney Nixon
Cameron Jackson, D.C.
P.O. Box 890008
Houston, TX 77289

VIA FACSIMILE
Twin City Fire Ins. Co.
Attn: Barbara Sachse

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0652-01
TWCC #:
Injured Employee:
Requestor: Cameron Jackson, D.C.
Respondent: Twin City Fire Ins. Co.
MAXIMUS Case #: TW05-0008

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 physician 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 physician is board certified in anesthesiology and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 physician 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 female who sustained a work related injury on _____. The patient reported that while at work she injured her right shoulder and bilateral knees when she fell. Initial treatment for this patient's condition included physical therapy, work restrictions and oral medications. An MRI of the right knee was reported to have suggested a tear of the meniscus in the right knee. The patient was referred to an orthopedic surgeon and subsequently underwent right knee arthroscopic surgery. The arthroscopic findings revealed chondral erosion

of the articular surface. Postoperatively she was treated with further therapy. In January 2001 the patient underwent right shoulder arthroscopic surgery that revealed impingement syndrome, followed by further therapy. The patient then changed treating physicians. The patient underwent a repeat arthroscopic surgery of her right shoulder, right knee, and an initial arthroscopic surgery of her left knee. Arthroscopic surgery of the right shoulder showed a small tear at the insertion of the rotator cuff that was repaired during surgery. Arthroscopic surgery of the right and left knee revealed chondral erosions and no meniscal tears, bilaterally. Post operatively, the patient was treated with further therapy. The patient continues with complaints of chronic pain.

Requested Services

Chronic Pain Management 5 times a week times 6 weeks (30 sessions).

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

Documents Submitted by Requestor:

1. Daily Progress Notes 6/22/01 - 4/5/02
2. History and Physical Report 4/2/02
3. MRI reports 6/4/01, 4/18/01, 4/4/01
4. Operative Notes 10/11/00, 3/3/01
5. EMG Report 4/17/01
6. Orthopedic Chart Notes 9/25/00 - 1/25/01
7. Behavioral Assessment 7/21/03
8. Daily Consult 10/25/02 – 3/12/04

Documents Submitted by Respondent:

1. Same as above

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a female who sustained a work related injury to her right shoulder and bilateral knees on _____. The MAXIMUS physician reviewer indicated that the patient underwent arthroscopic surgery of her right knee and right shoulder. The MAXIMUS physician reviewer noted that the patient underwent a repeat arthroscopic surgery of her right knee and right shoulder and further arthroscopic surgery of her left knee. The MAXIMUS physician reviewer also noted that both knees were found to have chondral erosions bilaterally and that the shoulder had a small tear at the insertion of the rotator cuff. The MAXIMUS physician reviewer further noted that the patient had undergone extensive physical therapy after all surgeries, rehabilitative exercises and strengthening programs. The MAXIMUS physician reviewer indicated that the patient continues with complaints of pain and has been recommended to attend a chronic pain management program. The MAXIMUS physician reviewer also indicated that the patient has a work related chronic pain condition that has not responded to conservative and interventional therapies and exhibits limitations of ADLs,

social functioning and adaptation within various settings. The MAXIMUS physician reviewer noted that the patient underwent psychological testing that indicated that patient would benefit from a multidisciplinary approach to treatment of her chronic pain condition. The MAXIMUS physician reviewer explained that there are no further surgical interventions and that the patient has exhausted conservative therapies including medical management for treatment of her condition. Therefore, the MAXIMUS physician consultant concluded that the requested chronic pain management 5 times a week for 6 weeks is medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

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.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,
MAXIMUS
Elizabeth McDonald
State Appeals Department
cc: Texas Workers Compensation Commission

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 7th day of February, 2005.

Signature of IRO Employee: _____
External Appeals Department