



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: HEALTH & MEDICAL PRACTICE ASSOC 324 N 23 RD STREET, SUITE 201 BEAUMONT TX 77707	MDR Tracking No.: M5-05-2707-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: GRAY INSURANCE CO C/O FOL BOX 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation provided included TWCC-60, explanation of benefits and CMS 1500s.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent stated that the requestor failed to submit the 'request for reconsideration' in accordance with Rule 133.304. Respondent further disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary.

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)
8-3-04 to 10-12-04	97035, 97140-59, 97032, and 95904	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	None

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. Therefore, no reimbursement is due for the medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division 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 7-19-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Codes 99204 and 73620-WP billed on 8-2-04 and 97035 billed on 8-4-04 had no EOBs submitted by either party. The requestor failed to submit the original and request for reconsideration CMS 1500s for these dates of service. Therefore, no review will be conducted and no reimbursement recommended.

Code 95904-WP billed on 8-4-04 was denied as 'A, no preauthorization obtained.' Per Rule 134.600 (h), initial diagnostic studies do not require preauthorization. Requestor states that the disputed NCV study was the first one. Recommend reimbursement as follows:

- $\$50.34 \times 125\% = \62.93

Code 95904-76 billed on 8-4-04 was denied as 'A, no preauthorization obtained.' Per Rule 134.600 (h), initial diagnostic studies do not require preauthorization. Modifier -76 indicates a repeat study. The bill was for five repeat studies @ \$62.93 each = \$314.65 therefore, preauthorization is not required. Recommend reimbursement as follows:

- $\$50.34 \times 125\% = 62.93 \times 5 = \314.65

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202, and 134.600

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 Division has determined that the requestor is entitled to reimbursement in the amount of \$377.58. In addition, the Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. Therefore, 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.

Findings and Decision by:

Medical Dispute Officer

9-21-05

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT:
IRO CASE NUMBER: M5-05-2707-01
NAME OF REQUESTOR: Health and Medical Practice
NAME OF PROVIDER: Patrick McMeans, M.D.
REVIEWED BY: Board Certified in Physical Medicine and Rehabilitation
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 08/30/05

Dear Health and Medical Practice:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for Texas Workers' Compensation Commission (TWCC) to randomly assign cases to IROs, TWCC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Physical Medicine and Rehabilitation and is currently listed on the TWCC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An initial medical examination dated ____ by Louis S. Puig, M.D.

Laboratory work collected on 07/29/04 at Christus St. Joseph Hospital

An initial report dated 08/02/04 from Patrick McMeans, M.D.

Treatment with Dr. McMeans dated 08/02/04, 08/04/04, 08/06/04, 08/12/04, 08/13/04, 08/17/04, 08/19/04, 08/20/04, 08/23/04, 08/24/04, 08/27/04, 08/30/04, 08/31/04, 09/03/04, 09/07/04, 09/09/04, 09/10/04, 09/16/04, 09/17/04, 09/21/04, 09/22/04, 09/24/04, 09/28/04, 10/01/04, 10/04/04, 10/06/04, 10/07/04, 10/08/04, 10/11/04, and 10/12/04

A Functional Capacity Evaluation (FCE) dated 08/10/04 with Dr. McMeans

A follow-up note from an unknown provider (no name or signature was available) dated 08/23/04 and 09/09/04

A precertification request dated 09/16/04 from Dr. McMeans formally requesting an MRI of the right foot and the first metatarsophalangeal joint

Another FCE dated 09/29/04 from Dr. McMeans

A follow-up evaluation from Dr. McMeans dated 09/30/04

Laboratory report dated 10/06/04 from Quest Diagnostic and signed by Darcey Kobs, M.D.

An additional follow-up evaluation with the unknown provider dated 10/13/04

An MRI of the right foot dated 10/26/04 and interpreted by Edward Knudson, M.D.

A Required Medical Evaluation (RME) dated 08/24/04 with Robert Whitsell, M.D.

A follow-up evaluation with the unknown provider dated 10/29/04

A TWCC-53 form dated 12/07/04

A request for reconsideration dated 05/11/05 from Dr. McMeans' office and signed by Jo Meek in the collections department

A letter to the medical review division of the Texas Workers' Compensation Commission (TWCC) dated 07/01/05 from S. Rhett Robinson at Flahive, Ogden, & Latson

Clinical History Summarized:

Dr. Puig evaluated the patient on ____ and diagnosed him with a possible right foot strain and a more likely inflammatory process of the right first metatarsal. He was instructed to elevate and apply ice, and take Ibuprofen or Aleve as needed. Laboratory work was also recommended to rule out gout. Dr. McMeans initially evaluated the patient on 08/02/04 and recommended

treatment consisting of ultrasound, joint mobilization, and therapeutic procedures to the right foot and right toes three times a week for six weeks. The patient attended therapy with Dr. McMeans from 08/02/04 through 10/12/04. The patient received electrical stimulation, massage, therapeutic activities, and ultrasound. An FCE dated 09/29/04 noted the patient was functioning in a sedentary physical demand level. An MRI of the right foot on 10/26/04 revealed a small joint effusion of the first metatarsophalangeal joint with a questionable abnormal signal that suggested possible ferromagnetic artifact that could be superficial or within the area. On 10/28/04, Dr. Whitsell performed an RME and felt the patient could return to work. Ms. Meek provided a request for reconsideration on 05/11/05. In a letter dated 07/01/05 from Flahive, Ogden, & Latson, the carrier's position was provided. It was noted the carrier disputed the provider showed the treatment underlying the charges were medically reasonable and necessary and further, the carrier challenged the charges were consistent with applicable fee guidelines.

Disputed Services:

Ultrasound, manual therapy techniques, electrical stimulation, and a nerve conditioning study from 08/02/04 through 09/28/04

Decision:

I disagree with the requestor. The ultrasound, manual therapy techniques, electrical stimulation, and a nerve conditioning study from 08/02/04 through 09/28/04 would not be reasonable or necessary.

Rationale/Basis for Decision:

In my opinion, the patient presented with a painful joint. Evaluation of that included an initial x-ray and blood chemistry profile. On examination by Dr. McMeans on 08/02/04, the patient was noted to have normal sensation, normal reflexes, and normal motor strength. Although the patient had some complaints of sensory changes, his examination was completely normal in the neurological assessment. Therefore, nerve conduction studies would not have been reasonable or necessary. It appeared this patient received quite a bit of passive treatment, including manual therapy techniques, electrical stimulation, and massage between the dates of 08/02/04 and 09/28/04. Although passive therapy may be performed for approximately a one week interval prior to active therapy, it should not have occurred for this entire length of time. This was not reasonable or necessary. If the patient was going to achieve a pain reduction from those techniques, it would have been noted within the first week of treatment. I also believe the FCE done at the initial time of the patient's injury was excessive and not reasonable or necessary. As a physical medicine and rehabilitation board certified physician, I often treat people with contusions or muscle sprains. We anticipate the patient's recovery from those injuries to occur fairly quickly. Most do not even require medical intervention and none of them require ongoing long term massage, electrical stimulation, or ultrasound treatment.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk **within twenty (20) calendar days** of your receipt of this decision (28 Texas Administrative Code 148.3).

This decision is deemed received by you **five (5) calendar days** after it was mailed and the first working day after the date this decision was placed in the carrier representative's box (28 Texas Administrative Code 102.5 (d)). A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P. O. Box 17787
Austin, TX 78744

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.

I hereby verify that a copy of this Independent Review Organization's decision was sent to TWCC via facsimile or U.S. Postal Service on 08/31/05 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel