



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: Integra Specialty Group, P.A. 517 North Carrier Parkway Suite G Grand Prairie, Texas 75050	MDR Tracking No.: M5-05-3012-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Hartford Underwriters Insurance Box 27	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 package, explanations of benefits, CMS 1500s and medical documentation
 POSITION SUMMARY: "Medically necessary" per the table of disputed services

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response was received from the Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-29-04 to 05-05-05	95851 (\$52.80 X 1 = \$52.80)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$4,300.97
	96004 (\$152.75 X 3 = \$458.25)		
	97032 (\$40.40 X 13 = \$525.20)		
	99213 (\$68.24 X 11 = \$750.64)		
	97110 (\$110.97 X 11 = \$1,220.67)		
	97110 (\$38.69 X 1 = \$38.69)		
	97110 (\$73.98 X 4 = \$295.92)		
	97110 (\$36.99 X 2 = \$73.98)		
	97140 (\$34.13 X 17 = \$580.21)		
	95832 (\$53.12 X 1 = \$53.12)		
	95832 (\$26.56 X 1 = \$26.56)		
	97035 (\$15.84 X 11 = \$174.24)		
	97035 (\$31.68 X 1 = \$31.68)		
	97012 (\$19.01 X 1 = \$19.01)		

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. The amount due from the carrier for the medical necessity issues equals \$4,300.97.

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 10-20-05, 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.

Review of CPT code 99080-73 dates of service 11-19-04 and 04-19-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$30.00 (\$15.00 X 2)**.

CPT code 95832 date of service 12-01-04 denied with denial code "97" (payment is included in the allowance for another service. The services listed under this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed. Per the 2002 Medical Fee Guideline code 95832 is considered to be a component procedure of code 99213 billed on the same date of service. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. No reimbursement recommended.

CPT code 97032 (2 units) date of service 02-01-05 denied with denial code "N" (we are in receipt of your bill for services. Payment or denial cannot be determined without medical records). The carrier made a payment of \$20.20. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation supporting the service in dispute. Additional reimbursement is recommended in the amount of **\$20.20**.

CPT codes 95832 and 95833 on date of service 02-16-05 denied with denial code "F" (the services listed under this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed). Per the 2002 Medical Fee Guideline codes 95832 and 95833 are considered to be a component procedure of code 99213 billed on the same date of service. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. No reimbursement recommended.

CPT code 97032 (2 units) date of service 04-13-05 denied with denial code "A" (preauthorization not obtained). Per the 2002 Medical Fee Guideline code 97032 does not require preauthorization. Reimbursement is recommended in the amount of **\$40.40**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rules 133.307(e)(2)(B) and 133.307(g)(3)(A-F)

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 \$4,391.57. 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:

11-10-05

Authorized Signature

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISION II – 11/8/05

TDI-WC Case Number:	
MDR Tracking Number:	M5-05-3012-01
Name of Patient:	
Name of URA/Payer:	Integra Specialty Group
Name of Provider: (ER, Hospital, or Other Facility)	Integra Specialty Group
Name of Physician: (Treating or Requesting)	Robert Murphy, DC

October 11, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence, examination and treatment records from the provider.
2. Multiple carrier reviews
3. Diagnostic imaging reports
4. Operative reports
5. Psychological evaluation
6. NCV/EMG reports
7. Designated doctor report
8. Examination reports from Andrew B. Small, M.D.
9. Report of R. Robert Inpuito, M.D.
10. Comprehensive Medical Analysis by Derek Martin, D.C.
11. Comprehensive Medical Analysis by Marsha Pastirik, R.N.
12. Reports of James J. Pollifrone, D.O.

After sustaining injury on ___ to both upper extremities, the claimant underwent post-operative rehabilitation after having right wrist surgery on 10/28/04 and left wrist surgery on 01/06/05.

REQUESTED SERVICE(S)

95851 ROM, 96004 physician review of information, 97032 electrical stimulation, 95832 muscle test, 97110 therapeutic exercises, 97140 manual therapy technique, 97035 ultrasound, 97012 mechanical traction, 99213 office visits (not marked as "fee") from 11/29/04 through 05/05/05.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Physical medicine is an accepted part of a rehabilitation program following surgery. However, for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains.

In this case, there is adequate documentation of objective and functional improvement in this patient's condition. Specifically, the patient's pain ratings significantly decreased after the right wrist surgery from 8/10 on 11/29/04 to 3/10 on 12/30/04 thus fulfilling statutory requirements¹ for medical necessity. In regard to the disputed treatment after the 01/06/05 left wrist surgery, the provider's post-operative treatment was both indicated and medically necessary. This position is supported in whole or in part by the surgeon's prescriptions for continuing treatment and the carrier reviewer who opined on 05/01/05 that all treatment through 04/02/05 had been "reasonable."

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

¹ Texas Labor Code 408.021

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Rule 102.4(h), 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 8th day of November 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell