



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

<b>Type of Requestor:</b> (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.: M5-05-3252-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DOCUMENTATION SUBMITTED: DWC-60 dispute package.

POSITION SUMMARY: From table of disputed services "appropriately documented".

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

DOCUMENTATION SUBMITTED: Response to DWC-60 package.

POSITION SUMMARY: This dispute involves the carrier's payment for date of service 12/4/2005 to 4/29/2005. The requester billed \$4,112.39; Texas Mutual paid \$0.00. The requester believes it is entitled to an additional of \$4,112.39.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-21-04 to 04-29-05	97032, 97140, 97035 and 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

#### 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.

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 09-27-05, 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.

On 10-10-05 the Requestor withdrew dates of service 12-21-04, 01-11-05, 01-17-05 and 01-31-05 from the table of disputed services. These dates of service will not be a part of the review.

CPT code 99213 dates of service 03-02-05, 03-04-05, 03-07-05, 03-09-05, 03-11-05, 03-15-05, 03-18-05, 03-21-05, 03-24-05, 03-28-05, 03-30-05, 04-05-05, 04-07-05, 04-12-05, 04-13-05, 04-15-05, 04-19-05, 04-21-05, 04-26-05, 04-27-05 and 04-29-05 denied with codes "57/864 and/or 858" (57-payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage or this day's supply, 864-E/M services may be reported only if the patient's condition requires a significant separately identifiable E/M service and 858- physical medicine and rehabilitation services may not be reported in conjunction with an E/M code performed on the same day). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation supporting the service billed for each date of service in dispute. Reimbursement is recommended in the amount of **\$1,433.04 (\$68.24 X 21 DOS)**.

CPT code 96004 dates of service 03-02-05, 03-04-05, 03-24-05 and 03-28-05 denied with denial code "225" (the submitted documentation does not support the service being billed, we will re-evaluate this upon receipt of clarifying information). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation supporting the services billed. Reimbursement is recommended in the amount of **\$611.00 (\$152.75 X 4 DOS)**.

CPT code 97140 date of service 03-04-05 denied with denial code "97" (payment is included in the allowance for another service/procedure). Per the 2002 Medical Fee Guideline code 97140 is global to code 95831 billed on date of service 03-04-05. No reimbursement is recommended.

CPT code 99080-73 date of service 03-23-05 denied with denial code "248" (TWCC-73 not properly completed or submitted in excess of the filing requirements; reimbursement denied per Rule 129.5. The Requestor submitted a copy of the TWCC-73 for review. Documentation supports the service billed per Rule 133.307(g)(3)(A-F). Reimbursement is recommended in the amount of **\$15.00**.

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

28 Texas Administrative Code Sec. 133.308, Rules 133.307(g)(3)(A-F), 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 reimbursement in the amount of \$2,059.04. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

12-29-05

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.**

# Envoy Medical Systems, LP

1726 Cricket Hollow  
Austin, Texas 78758

Phone 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

## NOTICE OF INDEPENDENT REVIEW DECISION

November 18, 2005

Re: IRO Case # M5-05-3252-01

Texas Department of Insurance, Division of Workers' Compensation:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) by the Texas Department of Insurance and has been authorized to perform independent reviews of medical necessity for Division of Workers' Compensation cases. Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that cases be assigned to certified IROs, this case was assigned to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation, and who has met the requirements for the Division of Workers' Compensation Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and the injured employee, the injured employee's employer, the carrier, the utilization review agent, any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

### Medical Information Reviewed

1. Table of disputed services
2. Explanation of benefits
3. DDE 5/24/05, Dr. Hawland
4. Operative reports 2/10/05, 9/21/04, 2/10/05, Dr. Yabraian
5. Follow up note 2/23/05
6. Strength testing reports 3/4/05, 5/20/05
7. ROM testing reports 3/2/05, 5/26/05
8. Physical therapy notes
9. Home exercise instruction sheets
10. MRI report 5/30/03
11. Lumbar MRI report 6/6/03
12. Left knee MRI report 6/6/03
13. Follow up note 1/17/05

### History

The patient was injured in \_\_\_ when he fell eight feet off a scaffold and landed on his back and left arm. He sustained injury to his neck, low back, left shoulder and left knee. He was started in physical therapy in May 2003. The first note available is dated 5/21/03. Therapeutic treatments included joint mobilization, traction, myofascial release, therapeutic exercises for the cervical spine, lumbar spine, knee and elbow. A 5/30/03 cervical MRI showed probable signal change, and posterior subluxation of C3 on C4. A 6/6/03 MRI of the left knee indicated a tear of the posterior horn of the medial meniscus. The patient continued some form of physical therapy continuously through 9/3/04. On 9/21/04 the patient underwent

arthoscopy and partial lateral meniscectomy. He continued to have pain in his shoulder despite physical therapy, and on 2/10/05 he underwent decompression acromioplasty.

Requested Service(s)

Electrical stimulation, manual therapy techniques, ultrasound, therapeutic exercises 12/21/04 – 4/29/05

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

Physical therapy was medically necessary and appropriate. Clinical guidelines recommend physical therapy up to 45 minutes per session for a maximum of three times per week on non consecutive days. The carrier has already approved and reimbursed the provider for services provided on including an average of three units of therapeutic exercises per session, as well as some passive modalities. The remainder of the services are in excess of clinical guidelines and accepted standards of practice.

This medical necessity decision by an Independent Review Organization is deemed to be a Division of Workers' Compensation decision and order.

Sincerely,

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Daniel Y. Chin, for GP