



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:	MDR Tracking No.: M5-06-0096-01
Health and Medical Practice 8713 9 th Avenue Port Arthur, TX 77642	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TX Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 packet. Position summary states, "Per Texas Labor Code 408.021 'Relief of the effects naturally resulting from the injury is sufficient by itself to support a finding of medical necessity in the workers' compensation system'".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "We have no record of receiving a bill for 1-26-05. As such, there is no EOB."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-23-04 – 2-17-05	CPT code 97140 (\$32.10 X 1 DOS + \$31.96 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$191.90
12-23-04 – 2-17-05	CPT code 97110 (\$35.12 X 3 units + \$33.74 X 13 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$543.94
12-23-04 – 2-17-05	CPT codes 97035, 97032, 97124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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. The amount due the requestor for the items denied for medical necessity is \$735.84.

Based on review of the disputed issues within the request, the 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.

Regarding CPT codes 97035, 97140 and 97110 on 1-26-05 and CPT code 97032 on 2-11-05: Per Rule 133.307 (e)(2)(A) a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with 133.304 must be provided to the Division. There are no CMS 1500's for these services. Recommend no reimbursement.

CPT code 97750 (16 units) on 1-27-05 was denied as "790-This charge was reduced in accordance to the TX Medical Fee", "143 – Portion of payment deferred" and "420-Supplemental payment." Per the 2002 MFG the MAR is \$35.81 per unit. The carrier has paid \$71.63. Recommend additional reimbursement of \$501.33.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307 (e)(2)(A), 133.308 and 134.202(c)(1).

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 requestor is not entitled to a refund of the IRO fee. The Division has determined that the requestor is entitled to reimbursement in the amount of \$1,237.31. 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 and Order by:

Donna Auby

12-27-05

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.

December 20, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-06-0096-01
DWC #:
Injured Employee: ____
Requestor: Health & Medical Practice Associates
Respondent: Texas Mutual
MAXIMUS Case #: TW05-0224

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 that 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 physician who is board certified in physical medicine and rehabilitation 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 22-year old male who sustained a work related injury on _____. The patient reported that he sustained an ankle injury while working as a water blaster laborer when a water pressure machine jerked backward hitting his left leg. He reported left lower leg pain with stiffness and burning and left ankle pain with stiffness and swelling. Evaluation and treatment have included a functional capacity evaluation, motor nerve conduction velocity testing and various physical therapy techniques. Diagnoses have included left ankle contusion, left ankle effusion, left ankle sprain/strain, left leg/lower extremity contusion, left ankle deep and superficial muscle spasm and left ankle crush injury.

Requested Services

Ultrasound (97035), manual therapy technique (97140), therapeutic exercises (97110), electrical stimulation (97032), and massage (97124) from 12/23/04-2/17/05.

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

Documents Submitted by Requestor:

1. Health & Medical Practice Associates Statement – 12/1/05
2. Physiotherapeutic Notes – 12/20/04-2/25/05
3. Daily Notes Report – 12/23/04-2/17/05
4. Medical Progress Notes – 12/28/04-2/3/05
5. Functional Capacity Evaluation – 1/27/05

6. Neuro-Selective CPT Laboratory Report Summary – 12/28/04
7. Motor Nerve Conduction Velocity Study – 12/23/04

Documents Submitted by Respondent:

1. Carrier's Statement – 11/17/05
2. Daily Notes Report – 12/20/04-2/25/05
3. Functional Capacity Evaluation – 1/27/05
4. Medical Progress Notes – 2/3/05

Decision

The Carrier's denial of authorization for the requested services is partially 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 physician reviewer noted that this 22-year old male sustained a work related injury to his left ankle on _____. The MAXIMUS physician reviewer indicated that an evaluation note dated 12/20/04 documents acute crepitus, severe muscle tonicity, very severe muscle hypertonicity and reduced motion, although there were no objective measures. The MAXIMUS physician reviewer also noted that subsequent notes reported continued crepitus, reduced range of motion, edema and hypertonicity of muscles. The MAXIMUS physician reviewer explained that as of 1/4/05, the patient still had moderate crepitus, mild edema, hypertonicity and moderately severe reduced motion in the left ankle. The MAXIMUS physician reviewer indicated that by 2/1/05 he was reported to have minimal creptis, nominal edema, nominal hypertonicity and a nominal measure of reduced motion was noted at the left ankle. The MAXIMUS physician reviewer noted a functional capacity evaluation performed on 1/27/05 included objective measures indicated reduced left ankle range of motion reduced by 50% in all planes and reduced active ankle muscle strength. The MAXIMUS physician reviewer noted that an MRI of the ankle was negative.

The MAXIMUS physician reviewer indicated the patient had been receiving ultrasound, manual therapeutic exercise, electrical stimulation and massage from 12/23/04-2/17/05. The MAXIMUS physician reviewer also noted that extensive types of modalities had been used for treatment of a relatively simple left ankle injury from direct trauma. The MAXIMUS physician reviewer noted there was no evidence of nerve damage to substantiate the need for electrical stimulation. The MAXIMUS physician reviewer explained that the use of electrical stimulation, ultrasound and massage was not medically necessary as they are not generally accepted standard treatment for acute injuries. The MAXIMUS physician reviewer explained that therapeutic exercise and manual therapy interventions were standard of care and medically necessary for treatment of this patient's condition.

Therefore, the MAXIMUS physician reviewer concluded that the ultrasound (97035), electrical stimulation (97032), and massage (97124) from 12/23/04-2/17/05 were not medically necessary to treat this patient's condition. The MAXIMUS physician reviewer also concluded that manual therapy technique (97140), therapeutic exercise (97110) from 12/23/04-2/1/05 were medically necessary to treat this patient's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department