



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:

**San Antonio Accident/Injury
401 W Commerce Suite 100
San Antonio TX 78207**

MDR Tracking No.: M5-06-0230-01

Claim No.:

Injured Worker's Name:

Respondent's Name and Address:

c/o Harris & Harris Box 42

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package, EOBs, CMS-1500s. Position Summary: Post OP-PT

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 response. Position Summary: Not medically necessary.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
1-5-05 TO 2-9-05	99213 (\$59.00 x 11 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$649.00
	97032 (\$19.81 x 10 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$198.10
	97124 (\$26.27 x 11 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$288.97
	97035 (\$15.11 x 7 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$105.77
	97150 (\$21.69 x 11days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$238.59
TOTAL			\$1,480.43

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.

Based on review of the disputed issues within the request, Medical Review 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 10-14-05, Medical Review submitted a Notice to the 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.

Code 99204-25 billed on 1-5-05 was denied as B13, previously paid. Per telecon on 11-7-05 with the requestor, this charge has not been paid. Recommend reimbursement of \$161.22.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 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 additional reimbursement in the amount of \$1,641.65.

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:

Medical Dispute Officer

11-18-05

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.

November 9, 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 #: M5-06-0230-01
DWC #:
Injured Employee: ____
Requestor: San Antonio Accident Injury
Respondent:
MAXIMUS Case #: TW05-0214

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 which 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 chiropractor 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 chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns an adult female who sustained a work related injury on _____. The patient reported that she sustained a work related injury to the right wrist from repetitive trauma as a data entry clerk. Evaluation and treatment have included MRI, EMG and nerve conduction studies, right carpal tunnel surgery (12/7/04), cortisone injections, medications, physical therapy and rehabilitation. Diagnoses have included right carpal tunnel syndrome, reflex sympathetic dystrophy syndrome, myofascial pain syndrome, and neuropathic pain.

Requested Services

Office visits – 99213, electrical stimulation (manual) – 97032, massage therapy – 97124, ultrasound – 97035 and group therapeutic procedures – 97150 from 1/5/05-2/9/05.

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

Documents Submitted by Requestor:

1. Request for Reconsideration – 10/19/05
2. Operative Report – 12/7/04
3. Report of Functional Capacity Evaluation – 2/8/05
4. MRI – 2/14/05
5. Workers Compensation Initial Evaluation Report – 1/5/05
6. Orthopedic Initial Consultation & Follow-up Notes – 1/5/05, 2/4/04, 2/21/05, 3/30/05.

Documents Submitted by Respondent:

1. Claim forms & Explanation of Review – 1/5/05-3/24/05

Decision

The Carrier's denial of authorization for the requested services is 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 chiropractor reviewer according to the medical records, the patient injured her right wrist on ___ and had carpal tunnel release surgery on 12/7/04 to the right wrist. The MAXIMUS chiropractor reviewer indicated she began postoperative rehabilitation on 1/5/05. The MAXIMUS chiropractor reviewer noted that according to the Official Disability Guidelines (Official Disability Guidelines, Work Loss Data Institute, 2005.), post surgical treatment for an open carpal tunnel release procedure is 20 visits in 10 weeks. The MAXIMUS chiropractor reviewer explained that the records reviewed show that the patient had 12 postoperative visits between 1/5/05-2/9/05. The MAXIMUS chiropractor reviewer indicated that the number of visits falls within these guidelines. The MAXIMUS chiropractor reviewer noted that the rehabilitation interventions for postoperative carpal tunnel release include EMS, therapeutic exercises, ultrasound, massage and periodic check-ups/office visits. (Maxey and Magnusson, Rehabilitation for the Post Surgical Patient, 2001) The MAXIMUS chiropractor reviewer explained that all of these services were treatments given to the patient after her surgery and were medically necessary for her rehabilitation.

Therefore, the MAXIMUS chiropractor consultant concluded that the Office visits – 99213, electrical stimulation (manual) – 97032, massage therapy – 97124, ultrasound – 97035 and group therapeutic procedures – 97150 from 1/5/05-2/9/05 were medically necessary for treatment of this patient's condition.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department