



## 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:	MDR Tracking No.: M5-06-0376-01
Integra Specialty Group, P. A. 517 North Carrier Parkway, Suite G Grand Prairie, TX 75050	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
TX Mutual Insurance Company, Box 54	

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

Documents include the DWC 60 package.

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

Documents include DWC 60 response. Position summary states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

#### 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)
3-3-05, 5-27-05	CPT code 99213 (\$68.24 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$136.48
3-3-05 – 6-22-05	CPT code 99211 (\$27.86 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$111.44
3-3-05 – 6-22-05	CPT code 97035 (\$15.59 X 8 Units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$124.72
3-3-05 – 6-22-05	CPT code 97032 – 1 unit per DOS (\$20.20 X 9 Units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$181.80
3-3-05 – 6-22-05	CPT code 97140 (\$34.13 X 8 Units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$273.04
3-3-05 – 6-22-05	CPT code 99213 on 5-10-05, 6-1-05 and 6-3-05; more than 1 unit of 97032; 96004; 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
6-24-05 – 7-13-05	CPT codes 99211, 99213, 97035, 97032, 97140, 97110, 96004	<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 \$827.48.

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.

On 11-16-05 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.

CPT code 95831 on 4-6-05 and 6-20-05 was denied as "97-Payment is included in the allowance for another procedure." Per the 2002 MFG CPT code 95831 is a component procedure of CPT code 99213 which was performed on these dates of service. The services represented by the code combination will not be paid separately.

CPT code 99211 on 6-24-05 was denied as "97-Payment is included in the allowance for another procedure." Per the 2002 MFG this CPT code is not global to any other service performed on this date. Recommend reimbursement of \$27.86.

CPT code 97032 on 6-24-05 was denied as "790-This charge was reduced in accordance with the Medical Fee Guideline." The Carrier reimbursed the requestor for one unit of this service. The IRO deemed only one unit of this service medically necessary per date of service. Per Rule 133.308(p)(5) an IRO decision is deemed to be a commission decision and order, therefore no additional reimbursement is recommended.

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

28 Texas Administrative Code Sec. 133.308 and Rule 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 Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement in the amount of \$855.34. 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

1-30-06

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.**

January 26, 2006

January 23, 2006

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

### AMENDED NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-06-0376-01**  
**DWC #:**  
**Injured Employee: \_\_\_\_**  
**Requestor: Integra Specialty Group, PA**  
**Respondent: Texas Mutual Ins.**  
**MAXIMUS Case #: TW05-0230**

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 chiropractor on the MAXIMUS external review panel that is familiar with the condition and treatment options at issue in this appeal. This case was also reviewed by a practicing chiropractor on the MAXIMUS external review panel that is familiar with the condition and treatment options at issue in this appeal. This physician is board certified in neurosurgery. The reviewers have met the requirements for the approved doctor list (ADL) of DWC or have been approved as an exception to the ADL requirement. A certification was signed that the reviewing providers have 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 reviewers certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns an adult male who sustained a work related injury on \_\_\_\_\_. The patient reported that he fell off of a machine and injured the top of his left hand. Diagnoses included wrist contusion and sprain, tenosynovitis and recurrent ganglion. Evaluation and treatment have included MRI, surgery and therapy.

#### Requested Services

Office visits 99211/99213, ultrasound-97035, electrical stimulation-97032, manual therapy technique-97140, therapeutic exercises-97110 and physician review and interpretation of comprehensive computer based motion analysis, etc with written report-96004 from 3/3/05-7/13/05.

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

##### *Documents Submitted by Requestor:*

1. Patient Treatment Timeline – 5/27/05-6/22/05
2. Operative Report – 6/4/04
3. Hand Surgeon Prescription for Physical & Occupational Therapy – 5/17/05
4. Integra Specialty Group Records – 5/27/05-6/24/05

*Documents Submitted by Respondent:*

1. Concentra Medical Centers Records – 4/2/04
2. Diagnostic Records (e.g. MRIs) – 4/14/04, 9/21/04
3. Operative Report – 6/4/04
4. Dallas Back Institute Records – 10/5/04
5. Work Hardening Progress Reports – 11/12/04
6. Designated Doctor Report – 12/3/04
7. Integra Specialty Group Records – 1/14/0-8/4/05
8. Robert Ippolito, MD Records – 3/15/05
9. Hospital Records – 4/22/05

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 chiropractor consultant indicated that the patient underwent a surgical procedure on his left wrist on 4/22/05 and he received a prescription for 9 sessions of post-operative physical and occupational therapy for 3 weeks at 3 visits per week. The MAXIMUS chiropractor consultant noted that since the records adequately documented that there were range of motion deficits in the left wrist, the medical necessity for manual therapy techniques (97140), as well as one unit only per encounter of attended electrical stimulation (97032) and ultrasound (97035) for dates of service 5/27/05 up through and including 6/22/05 (representing these 9 post-operative visits) was supported. The MAXIMUS chiropractor consultant also noted that without an objective assessment of the patient's status at the completion of the first 3 weeks and/or another prescription from the surgeon, all procedures for dates of service past 6/22/05 were unsupported as medically necessary.

The MAXIMUS chiropractor consultant explained the level I established patient office visits (99211), as well as the level III established patient office visits (99213) for dates of service 3/3/05 and 5/27/05 only are also supported as medically necessary. The MAXIMUS chiropractor also explained that in the case of 99213, it was appropriate for the treating doctor to evaluate and monitor the status of the patient on both those dates of service in March 2005 because the patient had not been in for a while, and on 5/27/05 because it was the first date he was seen post-operatively. The MAXIMUS chiropractor consultant indicated the remaining level III established patient visits were not supported as medically necessary because according to the Evaluation and Management (E/M) descriptions in CPT Manual, it is not necessary to perform this high level of service on a routine, visit-to-visit basis, particularly not during an established treatment plan. The MAXIMUS chiropractor consultant also indicated the level I office visit service, however, does not bear with it such high requirements and was supported as appropriate during the 9 visit time frame.

The MAXIMUS chiropractor consultant noted that insofar as the 2<sup>nd</sup> unit of attended electrical stimulation per date of service, nothing in either the diagnosis or the medical records in this case provided sufficient rationale to warrant the necessity for the prolonged application of this service (30 minutes). The MAXIMUS chiropractor consultant explained that without the appropriate documentation, medical necessity was not established.

The MAXIMUS chiropractor consultant noted that regarding the therapeutic exercises (97110), prior to this 2<sup>nd</sup> surgical procedure, this patient had already participated in over a year of supervised physical therapy and rehabilitation, as well as both a work conditioning and a work hardening program. The MAXIMUS chiropractor consultant explained that the provider failed to establish why the continuing services were required to be performed one-on-one, particularly when current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises. The MAXIMUS chiropractor consultant also explained that after months of monitored instruction, the patient should have certainly been able to safely perform the exercises on his own; but if not, the records should have explained the circumstances surrounding the need for continued supervision. The MAXIMUS chiropractor consultant indicated that any gains obtained in this time period would have likely been achieved through performance of a home program.

The MAXIMUS chiropractor consultant noted that regarding physician review and interpretation of comprehensive computer based motion analysis with written report (96004), according to the CPT Manual this service is defined as, "Physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report." The MAXIMUS chiropractor consultant also noted this injury does not involve the lower extremities, so "dynamic plantar measurements" and "dynamic surface electromyography during walking" are irrelevant in this case and therefore not medically necessary. The MAXIMUS chiropractor consultant explained that the code requires that a written report be submitted, and there was no evidence that such a report was submitted. (CPT 2004: American Medical Association Physician's Current Procedural Terminology, 4<sup>th</sup> Edition, Revised, Chicago, IL 1999, Ostelo RW, et al. Rehabilitation following first time lumbar disc surgery: a systematic review within the framework of the Cochrane collaboration. Spine. 2003 Feb 1:28(3):209-18)

Therefore, the MAXIMUS physician reviewer concluded that the office visits-99213 for dates of service 3/3/05 and 5/27/05, office visits-99211 from 3/3/05-6/22/05, and one unit per encounter of ultrasound-97035, electrical stimulation-97032, and manual therapy technique-97140 from 3/3/05-6/22/05 were medically necessary to treat this patient's condition. The MAXIMUS physician reviewer also concluded that the office visit - 99213 on 5/10/05, extra units of electrical stimulation-97032, office visits-99213 after 5/27/05, the physician review and interpretation of comprehensive computer based motion analysis, etc with written report-96004, therapeutic exercises-97110 and all services (99211/99213, 97035, 97032, 97140, 97110, 96004) from 6/22/05-7/13/05 were not medically necessary.

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.

Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department