



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.: M5-06-0423-01
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:
Zurich American Insurance Company, Box 19	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states (Table of Disputed Services), "Medically Necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Carrier asserts that the service rendered on these dates were neither reasonable nor necessary to treat the April 16, 2004."

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)
4-28-05	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$68.24
4-28-05 – 7-20-05	CPT code 99211	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$27.86
4-28-05 – 7-20-05	CPT code 99212 (\$48.99 x 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$293.94
4-28-05 – 7-20-05	CPT code 97140 (34.13 x 14 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$477.82
4-28-05 – 7-20-05	2 units per day of CPT code 97110 (\$36.14 x 16 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	578.24
4-28-05 – 7-20-05	CPT codes 99213 (except 4-28-05), 97032, 95851, 97035, 97112, 95833, more than 2 units of CPT code 97110	<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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$1,446.10. 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 code 99080-73 on 6-30-05: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). The IRO reviewer concluded that the office visit (99212) on date of service 06-30-05 was medically necessary. Based on Rule 133.308(p)(5) An IRO decision is deemed to be a commission decision and order, therefore reimbursement is also recommended for code 99080-73. Recommend reimbursement of \$15.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 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 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 for the services involved in this dispute in the amount of \$1,461.10. 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

1-9-06

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 4, 2006

TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-06-0423-01
DWC#:
Injured Employee: ____
DOI:
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in chiropractic, and is currently on the DWC Approved Doctor List.

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.

Sincerely,

Gilbert Prud'homme
General Counsel
GP:dd

REVIEWER'S REPORT
M5-06-0423-01

Information Provided for Review:

DWC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Office Notes / PT Notes 04/22/05 – 07/27/05

Range of Motion 03/30/05 – 08/25/05

Information provided by Respondent:

Designated Review

Orthopedics:

Office Visit 04/16/04

OR Report 04/17/04

Radiology Reports 04/16/04 – 04/17/04

Spine:

Office Notes 09/08/04 – 03/08/04

Clinical History:

Patient is a 35-year-old male construction worker who, on ____, fell from a dump truck and sustained a comminuted fracture of the mid shaft of his left radius and ulna, along with displacement of his bone shafts and angulations. On 4/17/04, the patient underwent a surgical procedure that included an open reduction, internal fixation, debridement and irrigation of the open fracture. The injury resulted in a non-union healing, so the patient was dispensed an external bone stimulator that was used for several months in conjunction with his physical therapy and rehabilitation.

Disputed Services:

Established patient office visits, levels I, II and III (99211, 99212 and 99213), therapeutic exercises (97110), electrical stimulation, attended (97032), manual therapy techniques (97140), range of motion testing (95851), muscle testing (95833), ultrasound (97035), and neuromuscular reeducation (97112) for dates of service 4/28/05 through 7/20/05.

Decision:

The reviewer partially agrees with the determination of the insurance carrier in this case, as follows:

The reviewer agrees to level III established patient office visit (99213) *performed on 4/28/05 only* as are all levels I and II established patient office visits (99211 and 99212); in addition, the manual therapy techniques (97140) and *two units only per encounter* of therapeutic exercises (97110) are approved. The reviewer disagrees with the insurance carrier on all remaining services and procedures, *including all other level III office visits and all therapeutic exercises in excess of two units per encounter.*

Rationale:

In this case, the specific diagnosis and the medical records adequately support the medical necessity for the treating doctor to perform periodic examinations and evaluations of the patient; so, the reevaluation (99213) performed on 4/28/05, as well as the lower level office visits performed thereafter, were supported as medically necessary. In addition, the records supported the presence of "palpable tenderness," "weakness," "fixations," and "muscular spasms," so the medical necessity of both manual therapy techniques (97140) and two units of therapeutic exercises (97110) were supported.

However, with regard to the neuromuscular reeducation services (97112), there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin 1, "This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular reeducation may be reasonable and necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine

motor coordination, hypo/hypertonicity). The documentation in the medical records must clearly identify the need for these treatments.” In this case, the documentation failed to fulfill these requirements, rendering the performance of this service medically unnecessary.

In terms of the attended electrical stimulation (97032), the medical records were devoid of any specific rationale concerning the continued usage of this modality, particularly so long after the injury and the surgery. In fact, when referencing this treatment modality, the records merely stated, “Patient received 2 units of electrical stimulation on: the forearm on the left,” on each and every date of service. Therefore, the medical necessity of its utilization was not supported.

With regard to the therapeutic exercises (97110), there was nothing in the records that supported multiple (more than two) units of this service. The involved area was clearly limited to the elbow and forearm, with weaknesses identified and documented in those areas only. Therefore, the medical necessity for more than two units of this procedure was unsupported.

Insofar as the level III established patient office visits, nothing in either the diagnosis in this case or the medical records submitted supported the medical necessity for performing this expanded level of Evaluation and Management (E/M) service on such a routine and frequent basis, and particularly not in the midst of an already-determined treatment plan.

Relative to the ultrasound therapy (97035), the documentation revealed that it was only reported on one date of service (5/13/05). However, the daily notes for that date failed to discuss the procedure at all, so no medical rationale regarding why it was necessary, where it was applied, etc., was provided. Since the documentation was devoid of any explanation regarding its application, the service was not supported as medically necessary.

Finally, with regard to the range of motion testing (95851) and the muscle strength testing (95833), unless there is a clearly documented extenuating circumstance (according to CPT2), these services are typically components of E/M services. And the documentation submitted revealed that E/M services were already performed on those same dates of service; so, repeating either range of motion or muscle testing on the same date was duplicative, and thereby medically unnecessary.