



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:  Beeville Medical Assoc. PO Box 33306 San Antonio, TX 78265-3306	MDR Tracking No.: M5-06-0590-01
	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

Documents include the DWC 60 package. Position summary states, "The additional units of time were supported with documentation of time spent, as well as individual program breakdown."

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

Documents include the 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)
5-4-05 – 6-16-05	HCPCS code E1399	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	DOP
5-4-05 – 6-16-05	CPT code 97110 (\$33.56 X 9 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$302.04
5-4-05 – 6-16-05	CPT code 97140 (\$31.79 X 22 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$699.38
	Grand Total		\$1,001.42

#### 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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$1,001.42 plus DOP amount.

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 12-16-05 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 97112 on 5-5-05 was originally denied as "790-this charge was reduced in accordance to the TX Medical Fee Guideline. The EOB shows that a payment was made. The resubmission audit shows no payment was made. The denial code is "790-This charge was reduced in accordance with the TX Medical Fee Guideline." The carrier made no payment and gave no valid reason for not doing so. Recommend reimbursement of \$35.21.

CPT code G0283 on 5-5-05 was originally denied as "790-this charge was reduced in accordance to the TX Medical Fee Guideline." The EOB shows that a payment was made. The resubmission audit shows no payment was made. The denial code is "891-The insurance company is reducing payment after reconsidering a bill." The carrier made no payment and gave no valid reason for not doing so. Recommend reimbursement of \$13.61.

CPT code 97140 on 5-19-05 was denied as "793-Reduction due to PPO contract." In a letter dated 1-26-06 the requestor states "there is no contract with this insurance company." Recommend reimbursement of \$31.79.

CPT code G0283 on 6-16-05 was denied as "793-Reduction due to PPO contract." In a letter dated 1-26-06 the requestor states "there is no contract with this insurance company." The carrier has made a payment of \$6.54. Recommend additional reimbursement of \$7.07.

#### **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 carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to reimbursement in the amount of \$1,089.10 plus DOP amount. 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:

\_\_\_\_\_  
Authorized Signature

Donna Auby

\_\_\_\_\_  
Typed Name

3-16-06

\_\_\_\_\_  
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.**

February 23, 2006

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 #: M5-06-0590-01**  
**DWC #:**  
**Requestor: Beeville Medical Associates**  
**Respondent: Texas Mutual Insurance Company**  
**MAXIMUS Case #: TW05-0245**

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 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 an adult male who sustained a work related injury on \_\_\_\_\_. The patient reported that he was pulling panels (approximately 5 x 20 feet) for a fence he was building when he lost his balance and fell. He also reported he fell hard which resulted in a left fifth proximal interphalangeal (PIP) joint fracture and injury to his back. Diagnoses included decreased range of motion, muscle weakness, gait difficulty and impaired activities of daily living. Evaluation and treatment have included physical therapy modalities including hot packs, electrical stimulation, therapeutic exercises, joint mobilization, soft tissue mobilization, home exercise program, and patient education.

#### **Requested Services**

E1399-Durable Medical Equipment, 97110-Therapeutic Exercises, and 97140-Manual Therapy Technique from 5/4/05-6/16/05.

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

*Documents Submitted by Requestor:*

1. Rehab Affiliates Records – 5/4/05-6/16/05

*Documents Submitted by Respondent:*

1. None submitted.

**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 physician consultant indicated the member had no prior history of neck or back pain. The MAXIMUS physician consultant noted that on initial examination by physical therapy on 5/4/05, the patient was reported to have mild to moderate limitation of range of motion (ROM) in the cervical and lumbar spine, mild lower extremity weakness and impaired activities of daily living (ADL) with a pain level at 4-6 on a scale of 1 to 10. The MAXIMUS physician consultant also noted the patient had another physical therapy evaluation on 5/19/05 where he was noted to have decreased ROM, lower extremity weakness, pain and impaired ADLs. The MAXIMUS physician consultant explained the patient had re-evaluation by physical therapy on 6/4/05 where he was reported to have some improvement in ROM in the neck and back areas and improved lower extremity strength. The MAXIMUS physician consultant indicated it was also reported he still had a pain level at 4-6 on a scale of 1 to 10 and had a slightly antalgic gait. The MAXIMUS physician consultant noted that physical therapy treatment continued through 6/15/05 when he was re-evaluated and found to have a pain level of 0-4 on a scale of 1 to 10 and had achieved his long term therapy goals. The MAXIMUS physician consultant also noted he was reported to have improved ROM in the neck and back and that lower extremity strength was near normal. The MAXIMUS physician consultant explained that physical therapy treatments consisted of therapeutic exercises, neurology re-education, and manual therapy with joint and soft tissue mobilization. The MAXIMUS physician consultant indicated there was no evidence in the case file of computer based motion analysis report or interpretation by the physician for review. The MAXIMUS physician consultant noted that physical therapy services from 5/6/05-6/16/05 were indicated to improve the patient's function and mobility and to decrease pain.

Therefore, the MAXIMUS physician consultant concluded that the E1399-Durable Medical Equipment, 97110-Therapeutic Exercises, and 97140-Manual Therapy Technique from 5/4/05-6/16/05 were medically necessary for treatment of the patient's condition.

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