



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.: M5-06-0845-01
Health and Medical Practice Associates 324 N. 23 rd St. Ste. 201 Beaumont, TX 77707	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. Position summary states, "Medical Necessity is indicated by subjective and objective findings on each visit."

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)
3-7-05 – 5-19-05 (back) 3-7-05 – 4-7-05 (neck)	CPT code 97032 (\$19.09 X 36 DOS) See note below.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$687.24
3-7-05 – 5-19-05 (neck)	CPT code 95904	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$63.75
4-26-05	CPT code 99245	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$269.01
3-7-05 – 5-19-05 (back) 3-7-05 – 4-7-05 (neck)	CPT code 97530 (\$35.34 X 8 DOS) See note below.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$282.72
4-12-05 – 5-19-05	CPT code 97124 (\$13.37 X 10 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$133.70
4-8-05 – 5-19-05	CPT codes 97032 (4-8-05 – 5-19-05 neck), 95900 and 95904 for the extremities, 97530 (4-8-05 – 5-19-05 neck)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
Grand total			\$1,436.42

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 not prevail on the majority of disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$1,436.42.

Note: The IRO decision stated that "97032-Electrical Stimulation" from 3-7-05 – 5-19-05 for the back and from 3-7-05 - 4-7-05 for the neck were medically necessary. Therefore, on dates of service between 3-7-05 and 4-7-05 where two units

were billed and both body areas were treated, both units are recommended to be reimbursed. On dates of service after 4-7-05 where two units were billed and both body areas were treated, only one unit is recommended to be reimbursed. On some dates of service this one unit has already been reimbursed by the insurance carrier and additional reimbursement will not be recommended.

Note: The IRO decision stated that “97530-Therapeutic Activities” from 3-7-05 – 5-19-05 for the back and from 3-7-05 - 4-7-05 for the neck were medically necessary. Therefore, on dates of service between 3-7-05 and 4-7-05 where two units were billed and both body areas were treated, only one unit is recommended to be reimbursed. On dates of service after 4-7-05 where two units were billed and both body areas were treated, only one unit is recommended to be reimbursed. In some cases, this one unit has already been reimbursed by the insurance carrier and additional reimbursement will not be recommended.

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 1-25-06 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 95900-WP-59 on 4-18-05 was denied by the carrier as “97-payment is included in the allowance for another service.” CPT code 95900 is considered by Medicare to be a component procedure of CPT code 95903. A modifier is allowed in order to differentiate between the services provided. The requestor used the modifier “59” to differentiate between the services. Recommend reimbursement of \$298.36 (\$74.59 X 4 units).

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 \$1,734.78. 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

3-16-06

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.

February 22, 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 #: M5-06-0845-01
DWC #:
Injured Employee:
Requestor: Health & Medical Practice Associates
Respondent: Texas Mutual
MAXIMUS Case #: TW06-0014

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 psychiatry 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 while restacking wood pallets his foot slipped off the blade of a forklift causing him to fall onto the concrete floor. He also reported that upon impact his elbow struck the forklift as he twisted his body to keep from falling and he fell on the entire right side of his body with his right shoulder taking the brunt of impact and causing his neck to snap to the right and left. Diagnoses included neck, shoulder and back pain, headaches, cervical and lumbar intervertebral disc displacement and cervical and lumbar radiculitis. Evaluation and treatment have included x-rays, MRI, medications and physical therapy.

Requested Services

Electrical stimulation (97032), nerve conduction tests no F wave (95900), sensory nerve tests each nerve (95904), office consultation new or established patient (99245), therapeutic activities (97530) and massage therapy (97124) from 3/7/05-5/19/05.

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

Documents Submitted by Requestor:

1. None submitted

Documents Submitted by Respondent:

1. Request for Appeal – 2/6/05
2. Health & Medical Practice Associate Records – 3/7/05-5/19/05
3. Functional Capacity Evaluation – 3/22/05
4. Designated Doctor Evaluation – 5/10/05
5. Diagnostic Studies (e.g., sensory nerve study, x-rays, NCV) – 3/11/05-3/21/05

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 consultant indicated the patient sustained a work related injury on ____ during a fall on a concrete floor. The MAXIMUS physician consultant noted that he was seen by a doctor on 3/8/05 where he was documented as having headaches, pain in the temple, neck pain and stiffness, severe right shoulder pain, numbness in the right shoulder, stabbing pain in low back and low back stiffness. The MAXIMUS physician consultant also noted the patient was reported to have muscle spasm in the cervical and lumbar regions along with hypertonicity of the muscles in these areas and reduced range of motion in the cervical/lumbar region. The MAXIMUS physician consultant explained that the patient was treated with electrical stimulation to decrease muscle spasms and therapeutic exercises to improve function. The MAXIMUS physician consultant indicated that progress notes documented continued muscle spasm, reduced range of motion and no significant change in symptoms on the visit dated 4/7/05 that was 4 weeks after the injury. The MAXIMUS physician consultant noted that, mild improvement in symptoms was reported on 6/14/05 but there was no change on examination of the patient. The MAXIMUS physician consultant indicated that massage therapy documented that on 5/3/05, only a mild level of muscle spasm remained as compared to a moderate level at the prior visit and moderately severe spasms were reported on 5/10/05. The MAXIMUS physician consultant noted that the last progress note included in the case file was dated 5/19/05.

The MAXIMUS physician consultant also noted the patient was seen by another doctor on 2/24/05 who felt the member had degenerative joint disease in the cervical and lumbar spine, right upper extremity radiculopathy, mild lumbosacral and upper abdominal pain. The MAXIMUS physician consultant explained that another treating doctor diagnosed that patient with cervical and lumbar intervertebral disc displacement and cervical radiculitis. The MAXIMUS physician consultant indicated the patient had a cervical MRI on 3/31/05 and was found to have C5-6 cervical stenosis, and diffuse disc protrusion at all levels with previous fusion at L4-5. The MAXIMUS physician consultant noted the patient had lumbar sensory nerve testing on 3/21/05. The MAXIMUS physician consultant indicated the patient had back pain but no significant symptoms indicating radiculopathy and therefore lumbar sensory nerve testing of the lower extremities on 3/21/05 was not medically necessary at the time. The MAXIMUS physician consultant noted that motor nerve conduction studies performed on the lower extremities on 3/15/05 were not necessary as he had no significant lower extremity symptoms such as weakness or pain at the time. The MAXIMUS physician consultant also noted cervical/upper extremity sensory/motor nerve studies performed on 3/17/05 on cervical area were necessary, but sensory motor nerve studies performed on the upper extremities on 3/17/05 were not medically necessary. The MAXIMUS physician consultant explained that documentation of symptoms and/or exam findings does not support the extensive electro-diagnostic studies. The MAXIMUS physician consultant indicated electrical stimulation, office consultation, therapeutic exercise, massage therapy from 4/12/05 forward was medically necessary to decrease pain and improve range of motion and function. The MAXIMUS physician consultant noted that the period of treatment provided 3/7/05-5/19/05 appears reasonable and in accordance with standards of practice except that only services pertaining to treatment of the back should have continued as of 4/7/05.

Therefore, the MAXIMUS physician consultant concluded that electrical stimulation (97032) from 3/7/05-5/19/05 for the back and from 3/7/05-4/7/05 for the neck, nerve conduction tests no F wave (95900) and sensory nerve tests each nerve (95904) for the cervical area, office consultation new or established patient (99245), therapeutic activities (97530) from

3/7/05-5/19/05 for the back and from 3/7/05-4/7/05 for the neck, and massage therapy (97124) from 4/12/05-5/19/05 were medically necessary for treatment of the member's condition. The MAXIMUS physician consultant concluded that electrical stimulation (97032) from 4/8/05-5/19/05 for the neck, nerve conduction tests no F wave (95900) and sensory nerve tests each nerve (95904) for the extremities, therapeutic activities (97530) from 4/8/05-5/19/05 for the neck were not 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