



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestors Name and Address: Integra Specialty Group, P.A. 517 North Carrier Parkway Suite G Grand Prairie, Texas 75050	MDR Tracking No.: M5-06-1061-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Hartford Underwriters Insurance Rep Box # 27	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute

POSITION SUMMARY: Per the table of disputed services "Medically necessary/claim not closed".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received from the Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-23-05 to 08-31-05	97032, 97035, 97110 (except for DOS below), 97140, 97112, 99212 (except for DOS below) and 95831	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
08-18-05	95832 (1 unit @ \$26.56)(see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
08-18-05	99212	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$48.99
08-19-05	95852 (1 unit)(see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
08-18-05, 08-19-05, 08-22-05 & 08-31-05	97110 (4 units @ \$144.56 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$578.24
	Note: This code although found to be medically necessary by the IRO per the 2002 Medical Fee Guideline is a component procedure of code 99212 billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.		
TOTAL			\$627.23

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 Requestor submitted an updated table of dispute services on 03-15-06 which is used for the review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 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 reimbursement in the amount of \$627.23. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

04-20-06

Authorized Signature

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.



CompPartners Final Report



CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: _____
Texas IRO #: _____
MDR #: M5-06-1061-01
Social Security #: _____
Treating Provider: Darren Howland, DC
Review: Chart
State: TX
Date Completed: 4/17/06

Review Data:

- Notification of IRO Assignment dated 2/27/06, 1 page.
- Receipt of Request dated 2/27/06, 1 page.
- Medical Dispute Resolution Request/Response dated 2/7/06, 1 page.
- List of Treating Providers (date unspecified), 1 page.
- Table of Disputed Services dated 8/31/05, 8/22/05, 8/19/05, 8/18/05, 8/16/05, 8/12/05, 7/14/05, 7/13/05, 7/11/05, 7/7/05, 7/1/05, 6/29/05, 6/28/05, 6/23/05, 5/27/05, 5/16/05, 5/2/05, 4/26/05, 4/13/05, 4 pages.
- Explanation of Reimbursement dated 8/31/05, 8/22/05, 8/19/05, 8/18/05, 8/16/05, 8/12/05, 7/14/05, 7/13/05, 7/11/05, 7/7/05, 7/1/05, 6/29/05, 6/28/05, 6/23/05, 5/27/05, 5/16/05, 5/2/05, 4/26/05, 4/13/05, 15 pages.
- Order for Payment of Independent Review Organization Fee dated 3/7/06, 1 page.
- Case Summary dated 3/15/06, 5 pages.
- Operative Report dated 7/18/05, 1 page.
- Cover Sheet dated 10/4/05, 1 page.
- Peer Review Final Report dated 10/3/05, 3 pages.
- Prescription dated 8/11/05, 6/21/05, 2 pages.
- SOAP Notes dated 7/13/05, 7/6/05, 6/23/05, 12 pages.

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for the following interventions with the dates of service 4/13/05 through 8/31/05:

1. Electrical stimulation (97032).
2. Ultrasound (97035).
3. Manual therapy technique (97140).
4. Office visits (99212, 99213).
5. Range of motion (ROM) (95851).
6. Therapeutic exercises (97110).
7. Neuromuscular re-education (97112).
8. Muscle testing (95831, 95832).
9. Neuromuscular proc evaluation (95852).

Determination: PARTIAL –

UPHELD - previously denied request for the following interventions with the dates of service 4/13/05 to 7/14/05:

- Electrical stimulation (97032).
- Ultrasound (97035).
- Manual therapy technique (97140).
- Office visits (99212, 99213).
- Range of motion (ROM) (95851).
- Therapeutic exercises (97110).

- Neuromuscular re-education (97112).
- Muscle testing (95831, 95832).
- Neuromuscular proc evaluation (95852).

UPHELD - previously denied request for the following interventions with the dates of service 8/12/05 to 8/31/05:

- Electrical stimulation (97032)
- Manual therapy technique (97140)
- Neuromuscular re-education (97112)
- Muscle testing (95831)

REVERSED - previously denied request for the following post-operative interventions with the dates of service 8/12/05 to 8/31/05:

- Ultrasound (97035)
- Office visits (99212)
- Range of motion (ROM) (95851)
- Therapeutic exercises (97110)
- Muscle testing (95832)
- Neuromuscular proc evaluation (95852)

Rationale:

Patient's age: :

Gender: Female

Date of Injury: ____

Mechanism of Injury: A heavy door closed on the claimant's right wrist, resulting in injuries to the right wrist.

Diagnoses: Laceration of the radial nerve in the right wrist in scapholunate tear and tenosynovitis.

While performing her normal job duties as a cleaner at the _____, a heavy door closed on the claimant's right wrist. The claimant underwent an extensive course of treatment, including stellate ganglion blocks for a diagnosis of reflex sympathetic dystrophy, in addition to psychological counseling. In January of 2003, the claimant underwent de Quervain's surgery, which apparently failed to resolve the claimant's condition. The claimant underwent further evaluations, including MRIs and electrodiagnostic studies. According to a previous peer review of 10/3/05, an MRI of the right wrist was obtained on 7/31/03. This revealed tenosynovitis of the "ECRB". This report further indicated that the claimant underwent a Required Medical Evaluation with Dr. Xeller on 1/31/05. Apparently, his conclusion was that the claimant had a neuroma of the radial nerve. An evaluation in mid-2005 by Dr. Ippolito documented that the claimant presented with wrist complaints that would be amenable to tenosynovectomy and neuroma excision. Concurrently, the claimant was being treated by a Dr. Downey, D.C., who performed physical therapy on the claimant. According to the IRO position statement report from Integra Specialty Group, dated 3/15/06, the claimant received pre-operative physical therapy that was recommended by Dr. Ippolito. The rationale was, "Dr. Ippolito stated that if the adhesions were not able to be reduced prior to the surgery, that her post-operative care would be significantly prolonged with a higher risk of failed surgery and interference during post-operative rehabilitation." Submitted for review was a prescription for pre-operative physical therapy from Dr. Ippolito, dated 6/21/05. On 7/18/05, the claimant underwent surgery for right radial nerve laceration and scapholunate ligament repair and tenosynovectomy. The surgeon then referred the claimant for three additional weeks of post-operative physical/occupational therapy on 8/11/05. On 8/12/2005 the claimant returned to the office of Dr. Downey and received six post-operative physical therapy treatments through 8/31/05. The purpose of this review is to determine the medical necessity for the physical therapy treatments rendered to this claimant from 4/13/05 through 8/31/05. On 10/3/05, a retrospective peer review was performed by Dr. Tsourmas, an orthopedist, to determine the medical necessity for the physical therapy treatments rendered to this claimant. According to the reviewer, the pre-operative treatments in April through July were not medically necessary. Following the review of the submitted documentation, this reviewer concurs with the evaluator that the treatments rendered to this claimant from 4/13/05 through 7/14/05 were not medically necessary. A review of the treatment notes for dates of service from 6/23/05 through 7/14/05 failed to provide an adequate rationale for this treatment. On 6/23/05, the claimant presented with pain complaints of 4/10 on the visual analogue scale (VAS). Treatment consisted of ultrasound, electrical muscle stimulation, joint mobilization and active exercise therapy. By 7/14/05, it was noted that the claimant's pain complaints remained at 4/10 on the visual analogue scale (VAS). Again, there was noted a 50 percent improvement in overall symptoms related to the compensable injury. There was no noted improvement in the claimant's objective findings. Over this timeframe, the claimant received eight physical therapy treatments. These eight treatments were not medically necessary or appropriate. Given the extensive level of treatment this claimant received prior to the 7/18/05 surgery, she should have had enough experience with the necessary stretches and exercises that she could have performed them at home. Moreover,

the continued delivery of passive modalities, such as ultrasound and electrical muscle stimulation, were not appropriate. The claimant was well past the acute phase of care, where the continued delivery of passive therapy could be considered appropriate. On 7/18/05, the claimant underwent surgery. This was followed by a recommendation for post-operative physical/occupational therapy. This post-operative rehabilitation for this claimant's complaints was clearly warranted. Dr. Tsourmas stated in his Peer Review report that post-operative therapy of twelve to fifteen visits over six weeks would be considered appropriate. He further stated that he questioned "whether a chiropractor has sufficient training and experience in this very refined area to appreciate the subtleties of Rehabilitation." While there may be some validity to this opinion, the provider will be given the benefit of the doubt and it will be considered that he was qualified to perform this therapy. It was clear that Dr. Ippolito had confidence in the provider's ability in that he referred this claimant to Dr. Downey for therapy. Therefore, certification of the six treatments rendered to this claimant from 8/12/05 through 8/31/05 will be recommended. The therapeutic exercises (97110) and an office visit for evaluation (99213) can be considered appropriate. The use of manual therapy (97140) and electrical muscle stimulation (97032) during the course of post-operative rehabilitation was not established. The claimant was well past the acute phase of care, where the use of passive therapies were appropriate. Neuromuscular re-education (97112) was also not appropriate. In summary, the medical necessity for the physical therapy treatments rendered to this claimant from 4/13/2005 through 7/14/2005 was not established. The six post-operative rehabilitation treatments for dates of service 8/12/2005 through 8/31/2005 to include therapeutic exercises (97110) and an office visit (99212) can be considered appropriate and medically necessary. The medical necessity for computerized range of motion testing of the hand (95851) and manual muscle testing of the hand (95832) were found to be appropriate. The medical necessity for muscle testing of the upper extremity (95831), excluding the hand, was not established. Periodic evaluations, including range of motion and muscle testing, are appropriate and, thus, the use of these interventions can be considered medically necessary.

Criteria/Guidelines utilized: TDI/DWC rules and regulations.

Diagnosis and Treatment Manual for Physicians and Therapist: Upper Extremity Rehabilitation, 4th Edition, Edited by Nancy M. Cannon, OTR, CHT.

Green's Operative Hand Surgery, Volumes 1 and 2, 4th Edition, edited by Green, Hotchkiss, and Pederson.

Physician Reviewers Specialty: Chiropractor

Physician Reviewers Qualifications: Texas Licensed M.D., and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.

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.