



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestor's Name and Address:

Integra Specialty Group, P. A.
 517 North Carrier Parkway, Suite G
 Grand Prairie, TX 75050

MDR Tracking No.: M5-06-1159-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

TX 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, "Documented medical necessity."

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)
7-14-05 – 9-28-05	CPT code 99212 (\$48.99 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$97.98
7-14-05 – 9-28-05	CPT code 97110 (\$36.14 X 18 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$650.52
7-14-05 – 9-28-05	CPT code 97032 (\$20.20 X 21 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$424.20
7-14-05 – 9-28-05	CPT code 97140 (\$34.13 X 10 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$341.30
7-14-05 – 9-28-05	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$68.24
	Total		\$1,582.24

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 medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$1,582.24.

Regarding CPT code 99213 on 7-14-05: The carrier reimbursed this service at \$45.65. Per the 2002 MFG the MAR for this service is \$68.31. The requestor billed \$68.24. Recommend additional reimbursement of \$22.59.

CPT code 95831 on 8-30-05 is considered by Medicare to be a component procedure of CPT code 99212 which was billed on this date. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

CPT code 95851 on 8-30-05 is considered by Medicare to be a component procedure of CPT code 97140 which was billed on this date. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

CPT code 99212 on 9-6-05, 9-7-05, and 9-13-05 was denied by the carrier as "790-this charge was reduced in accordance to the TX Medical Fee Guideline." The carrier reimbursed this service at \$31.10. Per the 2002 MFG the MAR for this service is \$50.23. The requestor billed \$48.99. Recommend additional reimbursement of \$53.67 (\$17.89 X 3 DOS).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 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 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 additional reimbursement in the amount of \$1,658.50. 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

4-24-06

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.

MATUTECH, INC.

**PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544**

April 18, 2006

Dee Torres
Texas Department of Insurance
Division of Workers' Compensation
Fax: (512) 804-4001

Re: Medical Dispute Resolution
MRD#: M5-06-1159-01
DWC#:
Injured Employee:
DOI:
IRO Certificate No.: IRO5317

Dear Ms. Torres:

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

Matutech certifies 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 the provider, 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 obtained from Basith Ghazali, M.D., and Integra Specialty Group, P.A. The Independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the DWC Approved Doctor list.

Sincerely,



John Kasperbauer
Matutech, Inc.

REVIEWER'S REPORT

Information provided for review:

Request for Independent Review

Information provided by Basith Ghazali, M.D.:

Office visits (7/11/05–10/12/05)
Surgery note (7/30/05)

Information provided by Integra Specialty Group, P.A.:

Therapy prescription (08/11/05)
Surgery note (07/30/05)
Office visits (08/16/05-09/13/05)

Clinical History:

This is 25-year-old male who presented to the Medical Center of Arlington emergency room (ER) for a knife injury at work with an 8-cm laceration of the left forearm and a resultant exposure of the flexor tendons. The injury was sutured and a short-arm volar splint was applied to the left forearm. Ancef and Motrin were prescribed and the patient was discharged home.

The patient was later seen by Darren Howland, D.C., who noted limited motion of the left forearm. He recommended physical therapy (PT) and referred the patient to a plastic surgeon. On July 14, 2005, the patient attended a single session of electrical stimulation (97032 – 2 units). On July 30, 2005, Basith Ghazali, M.D., a plastic surgeon, performed an exploration and repair of the flexor muscles and tendons with neurolysis and repair of the ulnar nerve. He referred the patient for PT.

From August 18, 2005, through September 13, 2005, the patient attended 10 sessions of PT consisting of electrical stimulation (97032 – 18 units), therapeutic exercises (97110 – 34 units), manual therapy (97140 – 9 units), and neuromuscular reeducation (97112 – 9 units). There were also nine office visits (99212, 99213) documented from July 14, 2005, through September 13, 2005, with Dr. Howland.

Dr. Ghazali noted that the patient was doing well. There was still decreased grip strength. He referred the patient back to Dr. Howland and recommended a functional capacity evaluation (FCE). In October, Dr. Ghazali referred the patient to PT for strengthening exercises two times a week for three weeks.

Disputed Services:

99212, 99213 – Office visit; 97032 – Electrical stimulation, 97140 – Manual therapy technique.

Explanation of Findings:

The patient was clearly injured on the job and was being treated for a post-surgical laceration to the middle part of the antebrachium. The therapy rendered was upon referral of the surgeon and the surgeon was clear that the patient was in need of 4 weeks of therapy at 3 times per week. It is not unusual or unexpected that extensive therapy is to be necessary after such a serious injury or surgical repair of such an injury. The care that was rendered was documented as being progressive in nature and the pain was decreasing for the most part. The care rendered was in compliance with good practice of physical medicine and is deemed to be reasonable and necessary.

Conclusion/Decision To Uphold, Overturn or Partially Uphold/Overturn denial:

The reviewer disagrees with the prior adverse determination and finds the care to be reasonable and necessary.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

TCA Guidelines to Quality Assurance, Mercy Guidelines, good clinical practice

The physician providing this review is a Doctor of Chiropractic. The reviewer has been in active practice for 14 years.

Matutech is forwarding this decision by mail and in the case of time sensitive matters by facsimile to the Texas Department of Insurance, Division of Workers Compensation.

Matutech retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by Matutech clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the Utilization Review Accreditation Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by Matutech represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to Matutech for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Matutech assumes no liability for the opinions of its contracted physicians and/or clinician advisors the health plan, organization or other party authorizing this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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.