



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: Health and Medical Practice Associates 324 N. 23 <sup>rd</sup> St. Ste. 201 Beaumont, TX 77707	MDR Tracking No.: M5-06-1252-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Gray Insurance Company, Box 19	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, "I request you initiate additional payment for the services performed on the above dates of service. All services performed were well within accepted standards of care."

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

Documents include the DWC 60 response. Position summary states, "The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary."

**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)
5-11-05 – 7-31-05	CPT code 97032 (\$19.09 X 22 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$419.98
5-11-05 – 7-31-05	CPT code 97530 (\$35.34 X 4 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$141.36
8-1-05 – 9-2-05	CPT codes 97032, 97530	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Grand Total		\$561.34

**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 \$561.34.

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 4-7-06 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 97124 on 9-2-05 was denied by the carrier as "Charges exceed your contractual/legislated fee arrangement." The requestor did submit a copy of the contract. Recommend reimbursement according to the contract.

**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 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 \$561.34 plus contracted amount for CPT code 97124. 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, Medical Dispute Officer

5-18-06

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

May 11, 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 #: M5-06-1252-01**  
**DWC #:**  
**Injured Employee: \_\_\_\_**  
**Requestor: Health & Medical Practice Associates**  
**Respondent: Gray Insurance Company/FOL**  
**MAXIMUS Case #: TW06-0063**

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 had a work related injury on \_\_\_\_\_. Records indicate that while working at a lumber mill he was pulling on three boards when he felt a pop in his back and experienced immediate pain in his back. Diagnoses included lumbar intervertebral disc, lumbar radiculitis, lumbar pain of discogenic origin, and myofasciitis. Evaluation and treatment has included MRIs, CT scans, physical therapy and surgery.

#### Requested Services

Electrical stimulation (97032) and therapeutic activities (97530) from 5/11/05-9/2/05.

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

*Documents Submitted by Requestor:*

1. Health Medical Practice Associates Records and Correspondence – 2/17/03-4/19/06
2. Diagnostic Studies (e.g., MRI, x-rays, myelogram, discogram, etc) – 12/26/03
3. Vista Medical Center Hospital Records – 11/12/04, 11/16/04
4. Medical Progress Notes – 6/20/03-3/8/06
5. Diagnostic Summary Evaluation – 8/25/05
6. Orthopedic Records and Correspondence (William R. Francis, MD) – 1/12/05-6/21/05
7. James Key, MD Records – 12/9/05
8. Operative Report – 6/21/04

*Documents Submitted by Respondent:*

1. Summary of Carrier's Position – 4/3/06, 4/18/06

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 to his back on \_\_\_\_\_. The MAXIMUS physician consultant noted that following several courses of conservative management including physical therapy and a work hardening program, the patient still had difficulty. The MAXIMUS physician consultant explained he also had extensive diagnostic testing including a CT scan, an MRI, a myelogram, and a discogram/CT. The MAXIMUS physician consultant also noted he was eventually felt to have mechanical fascet issues secondary to instability of the lumbar spine and lumbar instability and surgical treatment was recommended. The MAXIMUS physician consultant indicated the patient underwent multi-level posterior lumbar fusion surgery in November 2004 and was seen by an orthopedic surgeon for follow-up. The MAXIMUS physician consultant noted he started a pool exercise program in January 2005 and also wore a brace following surgery, and then a corset. The MAXIMUS physician consultant explained that in March 2005 he had landbased therapy mainly for the lower extremities and isometric abdominal exercise was started. The MAXIMUS physician consultant also explained that in April 2005 he started strengthening and muscle conditioning. The MAXIMUS physician consultant indicated the patient received physical therapy from 5/11/05 consisting of electrical stimulation to the lumbar area, massage, therapeutic exercise, including range of motion, stretching, lumbar stabilization, treadmill, bicycle, and isometric exercises. The MAXIMUS physician consultant noted that physical therapy notes documented reduced range of motion in the lumbar region (no objective measurements), and low back pain with stiffness and a burning sensation. The MAXIMUS physician consultant explained there was not much change in the patient's subjective complaints or with the objective findings throughout the course of treatment. The MAXIMUS

physician consultant also indicated that objective findings documented in the notes do not include any actual range of motion or muscle strength measurements and only state findings of muscle hypertonicity, muscle spasms in the lumbar region and reduced range of motion in the lumbar region. The MAXIMUS physician consultant indicated the therapy notes did not document whether the patient's ability to lift, walk or perform activities of daily living changed or improved. The MAXIMUS physician consultant explained that the orthopedic notes do not indicate or include any objective findings. The MAXIMUS physician consultant also explained that considering the extensive surgery the patient underwent and taking into consideration significant further deconditioning of the back and lower extremity muscles after surgery, physical therapy from 5/11/05-7/31/05 was medically necessary.

Therefore, the MAXIMUS physician consultant concluded that the electrical stimulation (97032) and therapeutic activities (97530) from 5/11/05-7/31/05 were supported as medically necessary. The MAXIMUS physician consultant also concluded that the electrical stimulation (97032) and therapeutic activities (97530) from 8/1/05-9/2/05 were not supported as medically necessary.

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