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: Summit Rehabilitation Centers 2420 E Randol Mill Rd. Arlington TX 76011	MDR Tracking No.: M5-06-1755-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Dallas National Insurance Company, Box 20	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "Provider sent a request for reconsideration…Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."
Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "Respondent maintains that it complied with the Texas Labor Code and the rules promulgated by the Division of Workers' Compensation. Thus, Respondent should not be responsible to reimburse Requestor any unnecessary fees."
Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. EOBs

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)
2-1-06	99213	☒ Yes ☐ No	$62.60< MAR per 134.202(d)(2)
1-20-06 – 2-22-06	97018, 97035, 97110, 99213 (except 2-1-06), 97140, 97124, 95851, 96004, 97530, G0283, 99080-73	☐ Yes ☒ No	$0.00

	Grand total		$62.60

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 disputed medical necessity issues. The amount due the Requestor for the items denied for medical necessity is $62.60.

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 8-23-06 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.

Regarding CPT code 99080-73 on 2-2-06: The Respondent denied this service as "50 - unnecessary medical treatment based on a peer review." The DWC-73 is a required report per Rule 129.5 and cannot be denied for medical necessity. Medical Dispute Resolution has jurisdiction in this matter. Recommend reimbursement of $15.00 according to 133.106(f)(1).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
28 Texas Administrative Code Sec. 134.1, 134.202, 133.308

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 $77.60. The Division hereby **ORDERS** the Respondent 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 by:

	Medical Dispute Officer	10-09-06
Authorized Signature	Typed Name	Date of Findings and Decision

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.

October 3, 2006
July 27, 2006

Texas Department of Insurance Division of Texas Worker's Compensation
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

AMENDED NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-06-1755-01
DWC #: ___
Injured Employee: ___
Requestor: Summit Rehab Centers
Respondent: Dallas National Insurance Company
MAXIMUS Case #: TW06-0110

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 chiropractor on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. This case was also reviewed by a practicing chiropractor 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 have been approved as an exception to the ADL requirement. A certification was signed that the reviewing chiropractic 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 chiropractic 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 report that while performing his usual duties, he fractured his forearm with 3 open fracture sites. Diagnoses included left forearm closed fracture, fracture of radius with ulna closed, stiffness of joint, scar and fibrosis of skin. Evaluation and treatment have included surgery, pain medications, physical therapy, chiropractic care and a wrist brace.

Requested Services

97018-paraffin bath, 97035-ultrasound, 97110-therapeutic exercises, 99213-office visits, 97140-manual therapy technique, 97124-massage, 95851-ROM, 96004-physician review of tests, 97530-therapeutic activities, G0283-electrical stimulation, 99080-73-DWC report from 1/20/06-2/22/06.

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

Documents Submitted by Requestor:

1. Summit Rehab Centers Correspondence and Records – 7/10/06
2. Designated Doctor Evaluation – 2/21/06
3. Chiropractic Clinical S.O.A.P. Notes – 1/20/06-2/22/06

Documents Submitted by Respondent:

1. None submitted.

Decision

The Carrier's denial 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 chiropractor consultant indicated that the medical records submitted for review adequately documented that a compensable injury to the claimant's left forearm occurred on ___, and that he underwent surgical repair that same date. The MAXIMUS chiropractor consultant noted that later, when symptoms persisted and he appeared to develop symptomatic mediated pain involving the left ulnar nerve, stellate ganglion blocks were administered. The MAXIMUS chiropractor consultant also noted some of the treatment in dispute in this case which represent post-injection therapy was supported as medically necessary, specifically the paraffin baths (97018), the ultrasound treatments (97035), the manual therapy techniques (97140), the unattended electrical stimulations (G0283), the therapeutic activities (97530), the DWC reports (99080-73), and a single level III office visit (99213) for date of service 2/1/06 only.

The MAXIMUS chiropractor consultant explained in terms of the range of motion study (95851) performed on 2/1/06, this service was not medically necessary because, according to CPT criteria (CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised. American Medical Association, Chicago, IL 1999), it is normally a procedure that is a component of an Evaluation and Management (E/M) service. The MAXIMUS chiropractor consultant indicated that since the records reflected that a separate E/M service was also performed on the same date this test was performed, and since there was no documented clinical rationale supporting why the range of motion study needed to be performed as a separate, distinct test

over and above the E/M, performing it again was duplicative and as such, not medically necessary.

The MAXIMUS chiropractor consultant noted that insofar as the massage therapy service (97124) performed on date of service 1/25/06, the records revealed that a "myofascial release" technique was also performed to the same area on that date of service. The MAXIMUS chiropractor consultant indicated that since this service has within it similar components of massage, the necessity of both these "overlapping" procedures on the same date of service was not supported as medically necessary.

The MAXIMUS chiropractor consultant noted that with regard to the therapeutic exercises (97110), nothing in medical records supported the clinical rationale for why it was still medically necessary to perform this service in a supervised, on-on-one clinical setting, as opposed to a home program. The MAXIMUS chiropractor consultant also noted that the records revealed that the patient had been performing supervised exercises in a clinical setting for months by the time the injection procedures were performed. The MAXIMUS chiropractor consultant explained that without anything in the records specifically to the contrary, the patient could have easily have been safely transitioned into a home program by that time period. The MAXIMUS chiropractor consultant indicated the medical literature reported, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises." (Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following fist-time lumbar disc surgery: a systematic review within the framework of the Cochrane collaboration, Spine. 2003 Feb 1:28 (3): 209-18)

The MAXIMUS chiropractor consultant indicated that in terms of the physician review of tests service (94004), according the CPT guidelines (CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised. American Medical Association, Chicago, IL 1999), this service is defined as, "Physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report." The MAXIMUS chiropractor consultant noted however, this injury does not involve the lower extremities, so, dynamic plantar measurements" and "dynamic surface electromyography during walking" are irrelevant in this case and therefore not medically necessary. The MAXIMUS chiropractor consultant indicated that the code requires that a written report be submitted, and upon review of the doctor's records, the statement, "I reviewed and signed the Jtech ROM/MT exam given to and will adjust treatment protocols as needed" is insufficient to qualify as a "written report".

The MAXIMUS chiropractor consultant noted that in terms of the level III established patient office visits (99213), other than date of service 2/1/06 (in the midst of the treatment dates in dispute), nothing in either the diagnosis or the medical records supported the performance of so high a level E/M service on such a routine, day-to-day basis, particularly not during an already established treatment plan and when the patient was under concurrent care with so many physicians. The MAXIMUS chiropractor consultant also noted this treatment would have been duplicative and accordingly, unsupported as medically necessary.

Therefore, the MAXIMUS physician consultant concluded that office visit (99213) for date of service 2/1/06 only was medically necessary for treatment of the member's condition. The MAXIMUS physician consultant also concluded that any services including 97018-paraffin bath, 97035-ultrasound, 97110-therapeutic exercises, 99213-office visits, 97140-manual therapy technique, 97124-massage, 95851-ROM, 96004-physician review of tests, 97530-therapeutic

activities, G0283-electrical stimulation, 99080-73-DWC report from 1/20/06-2/22/06 (except for that service noted above as medically necessary on 2/1/06) were not medically necessary for treatment of this member'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