



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Stephen Dudas, D.C. 2800 Forestwood # 130 Arlington, Texas 76006	MDR Tracking No.: M5-05-2895-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Zurich American Insurance Company Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 package, CMS 1500s, explanation of benefits and medical documentation  
POSITION SUMMARY: No position summary submitted by Requestor

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

No response was received from the Respondent by DWC

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07-06-04 to 02-04-05	97002 = \$99.92 97110 = \$1,639.61 99080 = \$25.00 97150 = \$173.52	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,938.05
07-06-04 to 02-04-05	G0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

#### 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 **prevailed** on the **majority** of disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review 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 09-09-2005, 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.

Dates of service 06-04-04 and 06-10-04 per Rule 133.308(e)(1) were not timely filed and will not be a part of the review.

CPT code 99080 date of service 07-30-04, code 99214 and 99080-73 date of service 08-05-04, code 99213 date of service 09-21-04 and code 99080 date of service 09-22-04 will not be a part of the review. Per Rule 133.307(e)(2)(A) the Requestor did not provide CMS 1500s for review.

Review of CPT code 99214 dates of service 07-06-04 and 09-10-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$203.48 (\$101.74 X 2 DOS)**.

Review of CPT code 99080-73 dates of service 07-06-04, 09-10-04 and 01-28-05 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended in the amount of **\$45.00 (\$15.00 X 3 DOS)**.

Review of HCPCS code A4645 date of service 09-15-04 revealed that neither party submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended. Per Rule 134.202, (6) "for products and services for which CMS or the Division does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value".

HCPCS code A4649 date of service 09-15-04 denied with denial code "F" (the services listed under this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed.). Per the 2002 Medical Fee Guideline HCPCS code A4649 is not global to any other procedure(s) billed on this date of service. Reimbursement is recommended. Per Rule 134.202(c)(6) "for products and services for which CMS or the Division does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value".

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 133.307(e)(2)(B), 133.308(e)(1), 133.307(e)(2)(A), 134.202(c)(1) and 134.202(c)(6)

#### **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 additional reimbursement in the amount of \$2,186.53. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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:

11-17-05

\_\_\_\_\_  
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.

**MEDICAL REVIEW OF TEXAS**

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

**REVISED 11/15/05**

TDI-WC Case Number:	
MDR Tracking Number:	M5-05-2895-01
Name of Patient:	
Name of URA/Payer:	Mega Rehab
Name of Provider: (ER, Hospital, or Other Facility)	Mega Rehab
Name of Physician: (Treating or Requesting)	Stephen Dudas, DC

September 28, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Division of Workers' Compensation

## CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Treating doctor of chiropractic initial evaluation and narrative report, dated 5/4/04
3. Treating doctor of chiropractic subsequent evaluations and reports, dated 6/4/04, 7/30/04, 11/2/04, 5/6/05, 7/27/05 and 8/30/05
4. Initial consultation by osteopathic physician, dated 5/6/04
5. Report on MRI of lumbar spine, dated 5/13/04
6. Nerve conduction studies and report, dated 6/10/04
7. Follow-up consultation by osteopathic physician, dated 6/24/04
8. Physical therapy initial evaluation and report, dated 5/7/04
9. Physical therapy reevaluations and reports, dated 7/2/04, 8/5/04, 11/16/04 and 1/28/05
10. Peer review report, dated 7/22/04
11. Orthopedic surgeon narrative report, dated 8/6/04 (NOTE: First page was missing)
12. Physical therapy "daily progress notes," multiple dates
13. Consultation and report from medical anesthesiologist, 8/18/04, dated 9/1/04, 9/9/04, 9/15/04, 10/13/04, 10/20/04
14. Caudal epidural steroid injection operative reports, dated 9/1/04, 9/15/04, and 10/13/04
15. Designated doctor report and TWCC-69, dated 5/11/05
16. "Patient Progress Summary" by doctor of chiropractic, dated 6/3/05
17. Various TWCC-73s

Patient is a 28-year-old production worker who, on \_\_\_\_, jerked/pulled a car seat that weighed an estimated 20 pounds off the line and twisted to the left to place it on a frame. Immediately upon doing so, he felt acute onset of lower back pain, accompanied by pain into his left lower extremity. He was seen initially at the emergency room, was diagnosed with a lumbar sprain/strain with associated radiculitis, but an eventual MRI scan of the lumbar spine revealed a 4mm disc "entral to left parasagittal soft tissue disc protrusion" at L5-S1 that effaced the thecal sac and displaced the left S1 nerve root sleeve. Nerve conduction studies performed on 6/10/04 were "relatively unremarkable" without "clear evidence of distal entrapment neuropathy."

Despite a trial of conservative management, including a trial of 3 epidural steroid injections, a lumbar fusion surgical procedure was eventually performed on 3/11/05, followed by post-surgical physical therapy and rehabilitation.

## REQUESTED SERVICE(S)

Therapeutic exercises (97110), electrical stimulation, unattended (G0283), physical therapy reevaluation (97002), copies of medical records (99080), and therapeutic exercises, group setting (97150) for dates of service 7/6/04 through 2/4/05.

## DECISION

The physical therapy reevaluations (97002), the therapeutic exercises (97110), copies of records (99080), and the group therapy therapeutic exercises (97150) are all approved.

The unattended electrical stimulation modalities (G0283) are denied.

## RATIONALE/BASIS FOR DECISION

The medical records submitted revealed that the patient sustained a compensable injury to his lower back that resulted in a disc protrusion at L5-S1 that effaced the thecal sac and displaced the left S1 nerve root. According to the records, this in turn caused a positive straight-leg raise on the left, muscular spasms and decreased lumbar range of motion in all directions.

But the medical records also revealed that – with treatment – the patient's range of motion improved, his maximum straight-leg raising increased, and his pain decreased during the dates of service in dispute. Therefore, the statutory requirements<sup>1</sup> for medical necessity were achieved with the treatment rendered since the patient obtained relief and promotion of recovery was accomplished.

However, in terms of the unattended electrical stimulation (G0283), the medical records were devoid of any specific

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<sup>1</sup> Texas Labor Code 408.021

objective rationale regarding the medical necessity of this passive modality so far into care, particularly when the patient had already been transitioned into the active phase of care during these dates in question. In addition, the records stated that the patient had been dispensed – and had been using – a home stimulator. Therefore, the application of this service in the office would have been duplicative, and accordingly, not medically necessary.

And finally, concerning the “peer review” supplied by the carrier, the health care provider performing the review was not a doctor of chiropractic. While it is understood that this patient had been seeing several health care providers during the course of his care, the fact still remains that his *treating doctor*, the provider in charge and coordinating care in this case, was a doctor of chiropractic and a true peer review should have been conducted by a like provider.

Furthermore, this peer reviewer stated that, “Evidence based medicine does not support physical therapy and chiropractic care in excess of 6-8 weeks in low back pain, regardless of the diagnosis,” but he makes no specific citation regarding this claim. Rather, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters 2* Chapter 8 under “Failure to Meet Treatment/Care Objectives” states, “After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) **without significant documented improvement**, manual procedures may no longer be appropriate and alternative care should be considered.” [emphasis added] It would appear that this reviewer omitted an important component of the medical literature in this case, as the records clearly indicated that the patient had, in fact, demonstrated “significant improvement” with the treatment provided.

#### Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

## 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.

Chief Clerk of Proceedings  
Division of Workers' Compensation  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this \_\_\_\_ day of November, 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell