



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:	MDR Tracking No.: M5-05-2992-01
Dr. David Rabbani 7447 Harwin, Suite 190 Houston, Texas 77036	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Hartford Underwriters Insurance, Box 27	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Documents included the TWCC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "I don't understand why the insurance companies employ the services of unqualified, incompetent and inexperienced doctors, who, in an attempt to justify their pitiful existence, hastily and without a complete and thorough review of the medical record would express their ludicrous, idiotic and absurd opinion regarding a patient care. The carriers refusal to respond to our request for reconsideration is in direct violation of TWCC rule 133.304."

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

No position summary or documents were received.

#### 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)
4-27-05 - 4-29-05	CPT codes 98940-AT, 97110, G0283, 97035	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$270.14

#### 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 disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$270.14.

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

28 Texas Administrative Code Sec. 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 parties are instructed to review the IRO decision and take appropriate action. 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 \$270.14. 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:

9-22-05

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

August 30, 2005

TEXAS WORKERS COMP. COMMISSION  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_\_

EMPLOYEE: \_\_\_\_

POLICY: M5-05-2992-01

CLIENT TRACKING NUMBER: M5-05-2992-01/5278

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Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

**Records Received:**

**RECORDS RECEIVED FROM THE STATE:**

Notification of IRO Assignment, Table of Disputed Service, Carrier EOB's, 7 pages

**RECORDS RECEIVED FROM DR. RABBANI (REQUESTOR):**

Treating doctor's statement of position, dated 8/23/05, 2 pages

Treating doctor's initial evaluation and narrative, dated 3/1/05, 4 pages

Treating doctor's daily notes and narratives, multiple dates, 4/4/05, 4/11/05, 5/9/05, 5/23/05, 6/28/05, 8/4/05, 8/17/05 16 pages

Lumbar MRI and left shoulder reports, dated 4/18/05, 3 pages

Plain film radiographic reports of left shoulder and lumbar spine, dated 4/18/05, 1 page

Pain management referral doctor report, dated 5/4/05, 2 pages

Carrier paper reviews, UniMed Direct LLC, dated 5/17/05 and 5/31/05, 9 pages

Operative report (SI joint block injection with arthrogram), dated 5/20/05, 2 pages

Orthopedic referral report, dated 6/6/05 with follow-up dated 6/27/05, 6 pages

Right knee MRI report, dated 8/12/05, 1 page

Copies of TWCC-49 forms, 3 pages

**Summary of Treatment/Case History:**

Patient is a 49-year-old maintenance technician for a property management company who, on \_\_\_\_, was riding in an elevator when it "overshot" the floor and suddenly shot back up to the proper floor. In so doing, the patient sustained injury to his lumbar spine, right knee and both his shoulders. Subsequent to that day, he developed pain in his left elbow. The "company doctor" initially saw him the next day, and he was evaluated, x-rayed and released with a prescription for medications and physical therapy. On 12/23/04, he was referred to an orthopedic surgeon who ordered an MRI of the left shoulder, and he then changed to a doctor of chiropractic in mid-February 2005 who began chiropractic care, and continued supervision of the patient's physical therapy and rehabilitation.

**Questions for Review:**

1. Are the following medically necessary for date of service 4/27/05 and 4/29/05 chiropractic manipulative treatment #98940, therapeutic exercise #97110, electrical stimulation (unattended) #G0283 and ultrasound #97035. Services denied by carrier for medical necessity.

**Explanation of Findings:**

1. Are the following medically necessary for date of service 4/27/05 and 4/29/05 chiropractic manipulative treatment #98940, therapeutic exercise #97110, electrical stimulation (unattended) #G0283 and ultrasound #97035. Services denied by carrier for medical necessity.

Yes. Dates of service 4/27/05 and 4/29/05 for chiropractic manipulative treatment #98940, therapeutic exercise #97110, electrical stimulation (unattended) #G0283 and ultrasound #97035 are medically necessary.

In this case, the records indicated that dates of service *before and after* the dates in dispute here had already been determined medically necessary by a previous IRO decision (approval was for chiropractic and physical therapy from 4/11/05 through 4/25/05 and then also from 5/11/05 through 5/16/05).

But expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does *not* produce the expected positive results, then it is not reasonable to continue with that course of treatment. But *with* documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains.

In this case, there was adequate documentation that the disputed treatment was reasonably expected to offer the patient relief, promote recovery and/or enhance the employee's ability to return to his employment. Specifically, even following the initial evaluation of 3/1/05, the shoulder range of motion had already improved by the first follow-up evaluation. Therefore, the medical records submitted demonstrated that the disputed treatment fulfilled the statutory requirements for medical necessity

**Conclusion/Decision to Certify:**

Dates of service 4/27/05 and 4/29/05 for chiropractic manipulative treatment #98940, therapeutic exercise #97110, electrical stimulation (unattended) #G0283 and ultrasound #97035 are medically necessary.

**References Used in Support of Decision:**

Texas Labor Code 408.021

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This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has given numerous presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty years.

MRIoA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

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

The written opinions provided by MRIoA 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 MRIoA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America 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 agrees to hold MRIoA harmless for any and all claims which may arise as a result of 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.

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