



**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:**  Health Care Provider    Injured Employee    Insurance Carrier

Requestor's Name and Address:  
 Main Rehab & Diagnostics/Administrative Office  
 3500 Oak Lawn Suite 380  
 Dallas, Texas 75219

MDR Tracking No.: M5-06-0389-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:  
 Texas Mutual Insurance  
 Box 54

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

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

**DOCUMENTATION SUBMITTED:** DWC-60 dispute package

**POSITION SUMMARY:** "We are requesting that the carrier be ordered to pay for these reasonable and necessary medical bills".

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

**DOCUMENTATION SUBMITTED:** Response to DWC-60

**POSITION SUMMARY:** Therefore, Texas Mutual requests that the request for dispute resolution filed by Main Rehabilitation & Diagnostic CTR be conducted under the provisions of the APA set out above.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-24-05, 04-18-05, 05-16-05, 05-18-05, 05-23-05, 05-25-05, 05-31-05, 06-02-05, 06-06-05, 06-08-05, 06-13-05, 06-20-05, 06-23-05, 06-27-05, 06-29-05, 07-05-05, 07-07-05, 07-12-05, 07-14-05, 07-18-05, 07-20-05, 07-25-05 and 07-26-05	97110-QU-GP (2 units) (\$69.85 X 21 DOS) = \$1,466.85 97530-QU-GP (1 unit) (\$36.77 X 21 DOS) = \$772.17 Note: Services were not billed on 03-24-05 or 04-18-05	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,239.02
07-26-05	95831-QU-GP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$35.22
03-24-05 to 07-27-05	99211-QU-GP, 97124-QU-GP, 97032-QU-GP, 97112-QU-GP, 97110-QU-GP (with the exception above), 97530-QU-GP (with the exception above), 95831-QU-59 (with the exception above)	<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 **did not prevail** on the **majority** of the 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 11-16-05, 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 97010-QU-GP dates of service 03-24-05, 03-25-05 and 04-18-05 were denied by the carrier as global. Code 97010 is a bundled service code and considered to be an integral part of a therapeutic procedure(s). Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code. Additional payment is not recommended.

CPT code 99080-QU date of service 05-31-05 was denied by the carrier as global. Per the 2002 Medical Fee Guideline code 99080-QU is not global to other services billed on date of service 05-31-05. Reimbursement is recommended in the amount of **\$10.00**.

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

28 Texas Administrative Code Sec. 133.308

**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 reimbursement in the amount of \$2,284.24. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

\_\_\_\_\_  
Authorized Signature

12-30-05

\_\_\_\_\_  
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]**

10817 W. Hwy. 71  
Phone: 512-288-3300

Austin, Texas 78735  
FAX: 512-288-3356

**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0389-01
Name of Patient:	
Name of URA/Payer:	Main Rehab & Diagnostics
Name of Provider: (ER, Hospital, or Other Facility)	Main Rehab & Diagnostics
Name of Physician: (Treating or Requesting)	Osler Kamath, DC

December 14, 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

Available documentation received and included for review consists of initial and subsequent reports and treatment records from Concentra - Dr. Morrow (DO), Kamath (DC), consulting doctor report from Drs. Malick (MD), Aggarwal (MD), designated doctor report Dr. Donovan (MD), MRI lumbar spine.

Mr. \_\_\_\_, a 52-year-old male, injured his lower back while employed as a carpenter for a construction company. He was lifting heavy steel rebar with two co-workers when he slipped and fell, twisting his lower back. He developed acute left anterior groin and testicle pain, along with some low back pain. He was initially seen at Concentra and told he had an inguinal hernia. Surgery was recommended, but declined by the patient. He changed treating doctors to Osler Kamath, DC who assessed him with a lumbar sprain/strain, and referred him to Dr. Malik, a general surgeon who ordered a bilateral testicular ultrasound that ruled out inguinal hernia. The patient then underwent extensive care including a mixture of active and passive modalities, three times a week for a total of 66 visits between 03/24/05 and 07/27/05.

MRI was obtained on 5/21/05 revealing a broad-based protrusion at L2/L3, mild central canal stenosis secondary to a 4 mm right paracentral disc protrusion at L3/4 and a broad-based 2 mm disc protrusion with moderate bilateral neural foraminal narrowing at L4/L5.

The patient was seen on 6/30/05 by Patrick Donovan, M.D. for designated doctor purposes. He felt that the patient was not at MMI and needed to undergo an aggressive program of lumbar stabilization. Patient continued with Dr. Kamath, and was seen for pain management consult by Dr. Aggarwal on 7/25/05. The patient was finally seen once more in September by Dr. Donovan and found to improved and at MMI.

### REQUESTED SERVICE(S)

Medical necessity of office visits (99211) therapeutic activities (97530), therapeutic exercises (97110), massage therapy (97124), neuromuscular reeducation (97112) electrical stimulation (97032) muscle testing extremity (95831). Dates of service 03/24/05 through 07/27/05.

### DECISION

Medical necessity for the following dates of service is established: 3/24/05, 4/18/05, 5/16/05, 5/18/05, 5/23/05, 5/25/05, 5/31/05, 6/2/05, 6/6/05, 6/8/05, 6/13/05, 6/15/05, 6/20/05, 6/23/05, 6/27/05, 6/29/05, 7/5/05, 7/7/05, 7/12/05, 7/14/05, 7/18/05, 7/20/05, 7/25/05, 7/26/05.

On the above dates of service, there is medical necessity for two units of therapeutic exercises (97110) and one unit of therapeutic activities (97530) only.

Medical necessity is also established for the code 95831, billed on 5/16/05 and 7/26/05.

Deny 97112, 97124, 97032 and 99211 on all dates of service.

Deny all services billed on 5/17/05, 5/19/05, 5/24/05, 5/26/05, 6/1/05, 6/7/05, 6/9/05, 6/14/05, 6/21/05, 6/30/05, 7/6/05, 7/13/05, 7/19/05, 7/21/05, 7/27/05.

#### RATIONALE/BASIS FOR DECISION

*The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.*

The patient was essentially focused exercise/rehabilitation program. As such, there is no documented requirement for the concurrent billing of office visit services. The standard timeframe for reassessment office visit services, according to Medicare guidelines, is once every two or three weeks, however no such "reevaluation/assessment" was performed. There is no medical necessity established here for an office visit service billed on 3/24/05, 3/25/05, and 4/18/05.

The care was certainly extensive and beyond traditionally accepted treatment guideline time frames for such an injury. However, considering the patient's age and potential complications from an inguinal/abdominal strain, treatments through 7/26/05 can be justified. The patient did seem to make some functional gains throughout this time frame, with a reduced level of pain and increased strength noted. The patient's response was also verified independently by designated doctor who as of 6/30/05 did not feel the patient was at MMI.

There was insufficient documentation to describe why "neuromuscular reeducation (97112)" was required, or even that it was performed. This seemed to be limited to activity such as walking in a side-by-side fashion on a treadmill, and should be considered part of the therapeutic activities/functional exercises that were also billed on the same dates of service. As such, medical necessity is not supported for this code. Likewise, no medical necessity was established in the documentation for massage, (97124), or electrical stimulation (97032).

The patient had numerous sequential "daily" visits which were not substantiated as necessary, especially at a point some two months into the rehabilitation program. Medical necessity was not established for such sequential dates.

#### References:

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

AMA Guides to the Evaluation of Physical Impairment, 4<sup>th</sup> Edition

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140

The Medical Disability Adviser, fourth edition (Presley Reed, MD.)

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.

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

Printed Name of IRO Employee: Cindy Mitchell