



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: Dr. Carlos Domino/Basu Law Firm P O BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-06-1343-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Federal Insurance Company Rep Box # 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "...The above indicates that the treatment provided for the claimant was medically reasonable and necessary. We are requesting reimbursement for all disputed dates of services".

Principle Documentation Submitted:

1. DWC-60/Table of Disputed Services
2. CMS 1500's
3. Explanation of benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: None submitted by Respondent

Principle Documentation Submitted: Response to DWC-60 including copy of peer review

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-15-05 to 08-10-05	98941-AT, 97110, 97140-59, 97012, 97035 and 98940-AT	<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 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 06-15-06, 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 99080-73 billed on date of service 06-18-05 was denied by the carrier with ANSI denial code "W9" (unnecessary medical treatment – peer review). Per Rule 129.5 this is a required report which is not subject to IRO review. The Medical Review Division has jurisdiction. Reimbursement is recommended in the amount of **\$15.00**.

CPT code 98941-AT billed on dates of service 04-13-05, 04-18-05, 04-20-05, 04-22-05, 04-27-05, 04-29-05, 05-04-05, 05-14-05 and 05-23-05 (1 unit for each date of service was billed for a total of 9 units) were denied by the carrier with denial code 16 (not all info needed for adjudication was supplied). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supported the services billed. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$422.46 (\$46.94 X 9 units)**.

CPT code 97140-59 billed on dates of service 04-13-05 (2 units), 04-18-05 (4 units), 04-20-05 (4 units), 04-22-05 (4 units), 04-27-05 (4 units) and 04-29-05 (4 units) were denied by the carrier with denial code 16 (not all info needed for adjudication was supplied). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supported the services billed. Note: Per the 2002 Medical Fee Guideline CPT code 97140-59 is a component procedure of code 98941-AT which was billed on each date of service in dispute. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The Requestor billed with an appropriate modifier. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$746.68 (\$33.94 X 22 units)**.

CPT code 97035 billed on dates of service 04-18-05, 04-20-05, 05-14-05, 05-23-05 and 05-31-05 (1 unit billed each date of service for a total of 5 units) were denied by the carrier with denial code 16 (not all info needed for adjudication was supplied). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supported the services billed. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$77.65 (\$15.53 x 5 units)**.

CPT code 72100 (1 unit) billed on date of service 04-20-05 was denied by the carrier with denial code 16 (not all info needed for adjudication was supplied). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supported the service billed. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$49.13**.

CPT code 97535 (1 unit) billed on date of service 04-29-05 was denied by the carrier with denial code 16 (not all info needed for adjudication was supplied). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supported the service billed. Reimbursement is recommended per Rule 134.202 in the amount of **\$38.13**.

CPT code 98941-AT billed on dates of service 04-30-05, 05-02-05, 05-18-05, 05-25-05, 05-31-05, 06-01-05 and 06-06-05 (1 unit billed each date of service for a total of 7 units) were denied by the carrier with denial code W1 (Workers' Compensation State Fee Schedule Adjustment). The carrier has made no payment. Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supported the service billed. Reimbursement is recommended per Rule 134.202 in the amount of **\$328.58 (\$46.94 X 7 units)**.

CPT code 97140-59 billed on dates of service 04-30-05 (4 units), 05-02-05 (4 units), 05-20-05 (4 units), 06-01-05 (4 units) and 06-06-05 (4 units) were denied by the carrier with denial code W1 (Workers' Compensation State Fee Schedule Adjustment). The carrier has made no payment. Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supported the service billed. Reimbursement is recommended per Rule 134.202 in the amount of **\$678.80 (\$33.94 X 20 units)**.

CPT code 97035 billed on dates of service 04-30-05, 05-02-05, 05-04-05 and 06-06-05 (1 unit billed each date of service for a total of 4 units) were denied by the carrier with denial code W1 (Workers' Compensation State Fee Schedule Adjustment). The carrier has made no payment. Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supported the service billed. Reimbursement is recommended per Rule 134.202 in the amount of **\$62.12 (\$15.53 X 4 units)**.

Review of CPT code 98941 (1 unit) billed on date of service 05-03-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the Requestor submitted convincing evidence that the carrier received the providers request for an EOB. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$46.94**.

Review of CPT code 97140-59 (4 units) billed on date of service 05-03-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the Requestor submitted convincing evidence that the carrier received the providers request for an EOB. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$135.76 (\$33.94 X 4 units)**.

Review of CPT code 97035 (1 unit) billed on date of service 05-03-05 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the Requestor submitted convincing evidence that the carrier received the providers request for an EOB. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$15.53**.

CPT code 97140-59 billed on dates of service 05-04-05 (4 units), 05-14-05 (4 units), 05-16-05 (4 units), 05-18-05 (4 units), 05-23-05 (4 units), 05-25-05 (4 units) and 05-31-05 (4 units) were denied by the carrier with denial codes 97/B15 (charge included in another charge or service/procedure/service is not paid separately). Per the 2002 Medical Fee Guideline CPT code 97140-59 is a component procedure of code 98941-AT which was billed on each date of service in dispute. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The Requestor billed with an appropriate modifier. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$950.32 (\$33.94 X 28 units)**.

CPT code 99050 (1 unit) billed on date of service 05-14-05 was denied by the carrier with denial code 97 (charge included in another charge or service). Per the 2002 Medical Fee Guideline code 99050 is not global to other services billed on date of service 05-14-05. Reimbursement is recommended per rule 134.202 in the amount of **\$100.00**.

CPT code 97024 (1 unit) billed on date of service 05-18-05 was denied by the carrier with denial code 97 (charge included in another charge or service). Per the 2002 Medical Fee Guideline code 97024 is not global to other services billed on date of service 05-18-05. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$6.86**.

CPT code 97012 (1 unit) billed on date of service 05-23-05 was denied by the carrier with denial code 16 (not all info needed for adjudication was supplied). Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation that supported the service billed. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$18.90**.

CPT code 97535 billed on date of service 05-25-05 was denied by the carrier with denial codes 97/B15 (charge included in another charge or service/procedure/service is not paid separately). Per the 2002 Medical Fee Guideline code 97535 is not global of other services billed on date of service 05-25-05. Reimbursement is recommended per Rule 134.202 in the amount of **\$35.00**.

Review of the explanation of benefits for services listed on the Table of Disputed Services for code 99214-25 and 99080-73 billed on date of service 04-13-05, code 98943-51 billed on date of service 05-04-05 and code 98941 billed on date of service 05-16-05 revealed that the carrier had made payment. Verification of payment was made with the Requestor via telephone on 07-10-06. These services are therefore no longer in dispute and will not be a part of the review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.307(g)(3)(A-F), 129.5, 134.202 and (c)(1)
Texas Labor Code 413.031

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 \$3,727.86. In addition, 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 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.

Ordered by:

07-24-06

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.



CompPartners Final Report ACCREDITED
EXTERNAL REVIEW

CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: _____
Texas IRO # : _____
MDR #: M5-06-1343-01
Social Security #: _____
Treating Provider: Carlos Domino, DC
Review: Chart
State: TX
Date Completed: 6/9/06
Amended Date: 6/12/06

Review Data:

- Notification of IRO Assignment dated 4/12/06, 1 page.
- Receipt of Request dated 4/12/06, 1 page.
- Medical Disputed Resolution Request/Response dated 3/24/06, 2 pages.
- List of Treating Providers (date unspecified), 1 page.
- Table of Disputed Services dated 8/10/05, 7/20/05, 7/18/05, 7/11/05, 7/5/05, 6/30/05, 6/28/05, 6/22/05, 6/20/05, 6/18/05, 6/15/05, 2 pages.
- Explanation of Review dated 8/10/05, 7/20/05, 7/18/05, 7/11/05, 7/5/05, 6/30/05, 6/28/05, 6/22/05, 6/20/05, 6/18/05, 6/15/05, 10 pages.
- Required Medical Evaluation dated 11/15/05, 3 pages.
- Report of Medical Evaluation dated 11/15/05, 8/30/05, 7/11/05, 3 pages.
- Texas Workers' Compensation Work Status Report dated 11/15/05, 8/25/05, 2 pages.
- Position Statement (date unspecified), 4 pages.
- Lumbar Spine MRI dated 5/24/05, 1 page.
- Designated Doctor Evaluation dated 8/30/05, 4 pages.
- Office Visits dated 7/28/05, 7/18/05, 5/22/05, 4/13/05, 6 pages.
- Functional Capacity Evaluation dated 6/20/05, 17 pages.
- Initial History and Physical dated 4/13/05, 3 pages.
- SOAP Notes dated 8/10/05, 7/20/05, 7/18/05, 7/11/05, 7/5/05, 6/30/05, 6/28/05, 6/24/05, 6/22/05, 6/20/05, 6/18/05, 6/15/05, 6/13/05, 6/8/05, 6/6/05, 6/1/05, 5/31/05, 5/25/05, 5/23/05, 5/20/05, 5/18/05, 5/16/05, 5/14/05, 5/4/05, 5/3/05, 5/2/05, 4/30/05, 4/29/05, 4/27/05, 4/22/05, 4/20/05, 4/18/05, 4/13/05, 33 pages.

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for:

1. Chiropractic manipulation spinal, 3 to 4 regions (98941-AT).
2. Therapeutic exercises (97110).
3. Manual therapy technique (97140-59).
4. Mechanical traction (97012).
5. Ultrasound (97035).
6. Chiropractic manipulation, 1 to 2 regions (98940-AT).
- 7.

Dates of service from 6/15/05 to 8/10/05.

Determination: UPHELD - the previously denied request for:

1. Chiropractic manipulation; spinal, 3 to 4 regions (98941-AT).

2. Therapeutic exercises (97110).
3. Manual therapy technique (97140-59).
4. Mechanical traction (97012).
5. Ultrasound (97035).
6. Chiropractic manipulation, 1 to 2 regions (98940-AT).

Dates of service from 6/15/05 to 8/10/05.

Rationale:

Patient's age:

Gender:

Date of Injury: ____

Mechanism of Injury: Picking up and moving boxes weighing 40-50 pounds, he felt a pull or pop sensation, involving the lower back.

Diagnoses: Sprain and strain of the lumbosacral spine; non-allopathic lesion, lumbar region; lumbago; spasm of muscle.

The patient has been treated with medications and chiropractic care. Richard Francis, M.D., an orthopedic surgeon, recommended epidural steroid injections, however, the patient had not pursued this. Dr. Domino, a chiropractor and the patient's primary care provider, released this patient back to full duties without restrictions on 4/13/05. The clinical daily notes corresponding to 4/13/05, documented that the pain was worse in the lower back and tailbone, with the intensity level rated at 7-8/10. His symptoms waxed and waned from 5-7/10, with same or worse circled on the patient questionnaire, up through at least 6/15/05. The dates of service in dispute, from 6/18/05 to at least 7/11/05, reflected that the pain intensity fluctuated from 4/10 to 6/10, with same or worse indicated. On 7/18/05, the pain was a 3/10, on 7/20/05 the pain level was a 4/10 and the same and, on 8/10/05, it was a 5-6/10 with symptoms marked the same. This data, therefore, reflected a clinical pattern which was worsening relative to the 6/18/05 date of service; not improving.

An MRI of the lumbar spine, performed on 5/24/05, identified a 3mm central and right para-central disc herniation at the L4-5 level, with obliteration of the right lateral recess. There was mild to moderate multifactor spinal canal stenosis at the L4-5 level. Other findings demonstrated a mild to moderate spinal canal stenosis. There was loss of the normal concavity of the posterior disc margin at the L5-S1 level.

The patient saw Richard Francis, M.D., on 7/28/05, at which time the objective findings documented a normal gait, a non-tender lumbar spine, negative straight leg raising, and neurological testing was normal with respect to reflexes, motor and sensory examinations. The patient was advised to submit to epidural steroid injections on this date, but the patient declined. The patient claimed to be 50% better.

On 8/30/05, the patient underwent a Designated Doctor Examination, performed by Alice D. Cox, MD, at which time he reported that his pain level was 5/10. He had a normal gait and posture. Lumbar ranges of motion were normal as were all orthopedic testing with normal sensation, reflexes and motor strength. He was not found to be at maximum medical improvement (MMI) because the claimant told Dr. Cox that he was anticipating surgery. Consequently, Dr. Cox clearly indicated in her report that the patient should be re-evaluated after the procedure. The data submitted for review did not document any surgical intervention. The fact that he has not yet been determined to be at MMI, appears to be based upon the patient's representation that he intended to submit to surgical intervention. A retrospective review of the medical records clearly refute those representations made by the patient to Dr. Cox.

He was then evaluated by Stephen Young, MD for a Required Medical Examination, on 11/15/05, at which time he described right-sided lower back pain. He denied radicular pain. Massage and adjustments made his pain better. His orthopedic and neurological examinations were normal. Muscle strength was normal, as were his reflexes. He did have a slightly larger left lower extremity, thought to be due to venous disease. He was not taking any medications at that time, and claimed that he did not miss any work. He was determined to have reached MMI and was rated at 0% impairment.

The SOAP notes or daily notes evaluated for this review failed to provide a signature from the provider. They failed to identify a particular subluxation or vertebral fixation level. There were no documented deficits in reflexes, motor examination, sensory examination, ranges of motion, gait disturbances or other identifiable orthopedic or neurological findings to support the medical necessity of the interventions in question hereunder. The notes were of the form check-off format, which were non-specific and inadequate to meet the minimum documentation requirements expected for reimbursement by most insurance carriers, as evidenced by reference to the Blue Cross / Blue Shield Chiropractic Manual pages, 6, 20, 21, 22 and 24.

The current request is to determine the medical necessity for disputed items from 6/15/05 to 8/10/05, which included services consisting of:

- 1) Chiropractic manipulation 3-4 regions (98941-AT) on 6/15/05, 6/18/05, 6/20/05, 6/22/05, 6/28/05, 6/30/05, 6/30/05 (duplicate), 7/5/05, 7/11/05, 7/18/05 and 7/20/05. The medical necessity for this charge (98941) for 3-4 regions was not found appropriate. This patient had one region documented and that was the lumbar spine. Clinical daily notes established objective findings only in the lumbar spine and, therefore, all charges corresponding to body parts beyond the lumbar spine cannot be recommended. Moreover, manipulation was not found medically necessary at all, due to the conspicuous absence of documentation of any subjective or objective improvements corresponding to the initial trial of care from at least 4/13/05 to 6/15/05. As discussed in the foregoing, the patient himself documented that he was the same or worse during the corresponding period. Furthermore, the data submitted for review reflected symptoms which fluctuated from 5/10 to 7/10, after two months of ongoing chiropractic care. The ACOEM Guidelines, Chapter 12 was referenced for this determination and states that a trial of manipulation for 3-4 weeks is appropriate, and if no improvements are documented specifically, then it should be stopped. This care should have been stopped by May or, certainly, no later than the June 1, 2005. Additionally, the clinical notes lack specific well documented subluxations or fixations at any particular vertebral level, and notes failed to identify the actual levels adjusted.
- 2) Therapeutic exercises (97110) on 6/15/05, 6/20/05, 6/30/05, 6/30/05 (duplicate) and 7/5/05. The medical necessity for this charge was not found due to lack of medical necessity. This claimant was returned to full duties without restrictions on 4/13/05, with findings throughout his care documenting a normal gait, normal dermatome levels and normal reflexes. Therefore, it is this reviewer's opinion that home exercises would have been appropriate by the dates in question. Moreover, given that no deficits were documented, the therapeutic exercises in question were clearly not medically necessary.
- 3) Manual therapy technique (97140-59) on 6/18/05, 6/22/05, 6/28/05, 7/18/05 and 7/20/05. The medical necessity for these services was not clinically established, and especially for four units on each date in question. There were no documented details of this manual therapy; with no specific body parts identified. Furthermore, manual therapy should not be charged on the same date as manipulation for the body part, which is inferred (by this reviewer) to be the lumbar spine in this case. Lastly, this treatment intervention afforded this patient no clinical improvement whatsoever. Accordingly, the manual therapy technique in question was not medically necessary.
- 4) Mechanical traction (97012) on 7/11/05 and 8/10/05. The medical necessity for these services was not found. The ACOEM Guidelines, Chapter 12, sets out that traction has not been found efficacious for lower back complaints.
- 5) Ultrasound (97035) on 7/18/05 and 7/20/05. The medical necessity for this service was not found with the provided documentation, as the patient was not improving with this passive intervention and, therefore, the ultrasound in question was not medically necessary.
- 6) Chiropractic spinal manipulation 1-2 regions (98940-AT) on 8/10/05. The medical necessity is not found for such services, based upon the provided documentation. The provider failed to document any subluxations at any particular vertebrae to support the medical necessity of these services. Most importantly is that chiropractic manipulation had failed to provide this patient with significant well-documented objective or subjective improvements. Based upon the foregoing, the chiropractic spinal manipulation in question was not medically necessary.

Criteria/Guidelines utilized: TDI/DWC Rules and Regulations.

- 1) ACOEM Guidelines, 2nd Edition, Chapter 12.
- 2) Blue Cross / Blue Shield Chiropractic Manual, pages, 6, 20, 21, 22, 24.

Physician Reviewers Specialty: Chiropractic

Physician Reviewers Qualifications: Texas Licensed DC, BSRT, FIAMA Chiropractor and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.

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, 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.