



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:
 Allied Multicare Centers
 415 Lake Air Drive
 Waco, Texas 76710

MDR Tracking No.: M5-06-1445-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
 Texas Mutual Insurance Company
 Rep 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: "This request for retrospective dispute resolution by an Independent Review Organization of our medical bill(s) pursuant to 133.304, it's being filed with the carrier and the division no later than one (1) year after the date(s) of service in the dispute".

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 ALLIED MULTICARE CENTERS, 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)
08-08-05 to 12-09-05	98940 and 97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
08-08-05 to 12-09-05	97110 (2 units @ \$67.12 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$201.36
	97110 (4 units @ \$134.24 X 12 DOS)		\$1,610.88
	97110 (1 unit @ \$33.56 X 4 DOS)		\$134.24
	97110 (3 units @ \$100.68 X 10 DOS)		\$1,006.80
	97530 (3 units @ \$103.95 < MAR X 1 DOS)		\$103.95
	97530 (1 unit @ \$34.65 < MAR X 2 DOS)		\$69.30
	97530 (2 units @ \$69.30 < MAR X 1 DOS)		\$69.30
	99212 (\$44.16 < MAR X 8 DOS)		\$353.28
	TOTAL		\$3,549.11

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 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 05-02-06, 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.

On 05-01-06 the Requestor withdrew dates of service 10-28-05 and 11-01-05 CPT code 97112, therefore these dates of service for this code will not be a part of the review.

CPT code 97112-GP (1 unit) dates of service 08-17-05, 08-19-05, 08-22-05, 08-24-05, 09-19-05 and 09-26-05 was denied by the carrier with denial code "97" (payment is included in the allowance for another service/procedure). Per the 2002 Medical Fee Guideline CPT code 97112 is a component procedure of code 98940 which was billed on the dates of service in dispute. A modifier is allowed in order to differentiate between the services provided. The Requestor billed with an appropriate modifier, therefore separate payment may be considered justifiable. Reimbursement is recommended in the amount of **\$205.80 (\$34.30 billed X 6 DOS)**.

CPT code 97530 (3 units) dates of service 09-23-05, 10-07-05, 10-11-05, 10-12-05 and 10-17-05 were denied by the carrier with denial code "45" (charges exceed our contracted/legislated fee arrangement). The carrier has made a payment of \$285.89. The carrier did not submit a copy of a contract. Additional reimbursement is recommended in the amount of **\$233.86 (\$519.75 billed minus carrier payment of \$285.89)**.

CPT code 97112 (1 unit) date of service 09-23-05 was denied by the carrier with denial code "45" (charges exceed our contracted/legislated fee arrangement). The carrier has not made a payment. The carrier did not submit a copy of a contract. Reimbursement is recommended in the amount of **\$34.30** billed by the Requestor.

CPT code 95831 (6 units) dates of service 10-18-05 and 11-30-05 were denied by the carrier with denial code "97" (payment is included in the allowance for another service/procedure). Review of the CMS 1500 submitted by the Requestor revealed that this was the only service billed on 10-18-05. The carrier has made a payment of \$53.68. Additional reimbursement is recommended in the amount of **\$276.68 (\$165.18 X 2 < MAR billed minus carrier payment)**.

CPT code 90801 date of service 11-17-05 was denied by the carrier with denial code "930" (preauthorization required, reimbursement denied). Preauthorization is not required for CPT code 90801. Reimbursement is recommended in the amount of **\$184.80** billed by the Requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202

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 \$4,484.55. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$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:

06-14-06

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.

MATUTECH, INC.

**PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544**

May 12, 2006

Texas Department of Insurance
Division of Workers' Compensation
Fax: (512) 804-4001

Re: Medical Dispute Resolution
MRD#: M5-06-1445-01
DWC#:
Injured Employee:
DOI:
IRO Certificate No. IRO5317

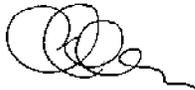
Dear Ms. :

Matutech, Inc. has performed an Independent review of the medical records of the above-named case to determine medical necessity. In performing this review, Matutech reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

Matutech certifies that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him the provider, 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 Independent Review Organization.

Information and medical records pertinent to this medical dispute were obtained from Med Rec 050260, Med REC_Allied Multicare 050506 and Payment. The Independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractics, and is currently on the DWC Approved Doctor list.

Sincerely,



John Kasperbauer
Matutech, Inc.

REVIEWER'S REPORT

Information provided for review:

Request for Independent Review

Information provided by Allied Multicare:

Office notes (12/13/2005 – 2/8/2006)
Radiodiagnostic studies (11/24/2004 – 10/10/2005)
Electrodiagnostic study (3/1/2005)
Procedure note (4/27/2005)
Therapy notes (12/13/2004 – 2/8/2006)

Clinical History:

This is a 36-year-old male who injured his back when he slipped on a creeper while getting up off the ground.

Magnetic resonance imaging (MRI) of the lumbar spine from June 2004 had revealed: a left paracentral disc herniation at L3-L4 and degenerative spondylitic changes from L3 through S1.

Following the injury of ____, MRI of the lumbar spine revealed postoperative changes to the left of the midline at L3-L4 level consistent with the history and degenerative spondylitic changes throughout the lumbar spine. Micah Mordecai, D.C., obtained x-rays which revealed decreased disc space at L4-L5 and L5-S1; mild facet tropism; and possible transitional segment at L5. Dr. Mordecai diagnosed lumbar hyperflexion/hyperextension and lumbar intervertebral disc syndrome. From December 2004 through April 2005, the patient attended 43 sessions of physical therapy (PT) consisting of electrical stimulation, myofascial release, chiropractic adjustments, therapeutic exercises, therapeutic activities, neuromuscular re-education, and diathermy. Les Benson, M.D., noted the patient had had a back injury in ____, for which he had undergone a discectomy at L3-L4. Lumbar myelogram revealed posterior and left lateral disc protrusion at L3-L4, a 5-mm retrolisthesis of L4 on L5, and prominent anterior epidural space posterior to L5 and L5-S1. Computerized tomography (CT) revealed a small laminectomy defect along the medial left side of the L3 lamina consistent with previous surgery and some soft tissue density possibly reflecting epidural fibrosis (recurrent disc protrusion could not be excluded). An Electromyography/nerve conduction velocity (EMG/NCV) study revealed left mild lumbosacral radiculopathy, unspecified site.

On April 27, 2005, Marcial Lewin, M.D., performed bilateral decompressive laminectomy and posterior lumbar interbody fusion (PLIF) at L4-L5. Follow-up x-rays of the lumbar spine revealed postsurgical changes from L4 through L5 and spondylitic changes at L5-S1. From August 8, 2005, through December 9, 2005, the patient attended 36 sessions of PT consisting of chiropractic adjustments, therapeutic exercises,

neuromuscular reeducation, therapeutic activities, and soft tissue manipulation. Dr. Benson noted that the patient had an injury in _____. The patient complained of anxiety, depression, and dyspepsia. He also had a history of seizures. He was taking Depakote and Tegretol. Dr. Benson diagnosed radiculopathy and organic affective disorder. He prescribed Nexium and Ambien.

In a designated doctor evaluation (DDE), Lewis Merrell, M.D., noted that the patient had undergone left discectomy and decompression of L3-L4 in 2004. Dr. Merrell assessed clinical maximum medical improvement (MMI) as of October 6, 2005, and assigned whole person impairment (WPI) rating of 10%. CT of the lumbar spine revealed: (a) degenerative osteophytes arising from the left aspect of the inferior L3 vertebral body resulting in narrowing of the left L3-L4 neural foramen; (b) postsurgical changes at L4-L5; and (c) degenerative disc disease (DDD) at L5-S1. Dr. Lewin noted the patient was doing quite well after completion of PT.

2006: Dr. Benson evaluated the patient for back pain radiating to the left leg associated with weakness. The patient also complained of stool incontinence. He was taking Tegretol and Depakote. Darvocet and Ambien were prescribed. On February 8, 2006, Dr. Lewin stated the incontinence was not related to back rather to a gastrointestinal (GI) problem. He referred the patient for GI consultation.

Disputed Services:

Chiropractic manipulative treatment (98940), therapeutic exercises (97110), neuromuscular reeducation (97112), therapeutic activities (97530), and office visits (99212).
(08/08/2005 - 12/09/2005)

Explanation of Findings:

According to the medical records provided for review, the claimant was injured on _____. The claimant underwent surgery to the lumbar spine on 4-27-05 and was released by the surgeon to begin post operative rehabilitation on 8-15-05. The dates of service in question were 8-8-05 to 12-9-05 in which therapeutic exercises, therapeutic activities, office visits, chiropractic manipulations, and neuromuscular re-education. According to the North American Spine Society's phase III clinical guidelines for multidisciplinary spine care specialists, 2003, the initial and secondary phases of care (which includes post operative rehabilitation) can last up to 16 weeks. Interventions included in these phases of care are: therapeutic exercises, passive modalities, spinal manipulations, manual therapy, and medications. Using the previously stated guidelines, the therapeutic exercises, office visits, and therapeutic activities from 8-8-05 to 12-9-05 were medically necessary to treat this claimant.

With regards to the neuromuscular re-education performed from 8-8-05 to 12-9-05, the medical records do not show that the claimant had any problems with coordination, balance, kinesthetic sense, posture, or proprioception. Thus, medical necessity for neuromuscular re-education was not shown for this claimant.

With regards to the chiropractic manipulations performed from 8-8-05 to 12-9-05, the medical records do not reveal the need for manipulations to the lumbar spine. The daily notes do not document any vertebral fixations or subluxations in the lumbar spine which would justify the need for adjustments. Objective findings in the daily notes found only trigger points and muscle spasms noted without mention of spinal subluxations or fixations. Thus, without objective findings warranting adjustments, the chiropractic manipulations were not medically necessary from 8-8-05 to 12-9-05.

In short, the therapeutic exercises, therapeutic activities, and office visits from 8-8-05 to 12-9-05 were medically necessary to treat this claimant. However, the chiropractic manipulations and neuromuscular re-education from 8-8-05 to 12-9-05 were not medically necessary to treat this claimant.

Conclusion/Decision To Uphold, Overturn or Partially Uphold/Overturn denial:

Partially Uphold

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

North American Spine Society's phase III clinical guidelines for multidisciplinary spine care specialists, 2003

The physician providing this review is a chiropractor. The reviewer is national board certified in chiropractic. The reviewer has been in active practice for seven years.

Matutech is forwarding this decision by mail and in the case of time sensitive matters by facsimile to the Texas Department of Insurance, Division of Workers Compensation.

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

The written opinions provided by Matutech 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 Matutech for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Matutech 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. 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.

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.