



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

Requestors Name and Address:  
Allied Multicare Centers  
415 Lake Air Drive  
Waco, Texas 76710

MDR Tracking No.: M5-06-1912-01 (current MDR#)  
M4-06-2713-01 (former MDR#)

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

Requestor's Position Summary: "This request for retrospective necessity 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."

Principle Documentation:

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: The position statement submitted by Texas Mutual does not address the disputed services.

Principle Documentation:

1. Response to DWC 60

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-10-05, 06-15-05, 06-22-05, 06-24-05 and 06-27-05	98940 (1 unit @ \$31.35 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$156.75
06-20-05, 06-22-05 and 07-01-05	97124 (1 unit @ \$26.28 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$78.84
06-22-05 to 09-02-05	97110, 97112, 98940, 97124, 99212 and 97530	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

	<b>TOTAL DUE</b>		<b>\$235.59</b>
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**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, Medical Dispute Resolution has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained fee issues that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 08-30-2006, Medical Dispute Resolution 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.

The Requestor submitted an updated Table of Disputed Services to Medical Dispute Resolution on 10-13-06 which is used for the review of the services in dispute.

CPT code 97124-GP billed for date of service 06-10-05 was denied by the Respondent with denial codes "W2" (Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment), "245" (the carrier is disputing the liability of the claim or compensation of the injury. Final adjudication has not taken place), "W4" (no additional reimbursement allowed after review of appeal/reconsideration) "97" (payment is included in the allowance for another service/procedure), "891" (the insurance company is reducing or denying payment after reconsidering a bill) and "435" (per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure). It was determined at a Contested Case Hearing held on 10-10-05 that the claimant sustained a compensable low back injury during the course and scope of employment on [redacted]. The Requestor billed with diagnosis code of 846.0 and treated the lumbosacral sprain/strain. Per Rule 134.202 CPT code 97124 is a component procedure of CPT code 98940 billed for the date of service in dispute. Separate payment for the service billed is considered justifiable if an appropriate modifier is used to differentiate between the services provided. The Requestor billed with a modifier, however, the modifier is not an appropriate modifier for separate reimbursement, therefore, no reimbursement is recommended.

CPT code 95831-59 (5 units) billed for date of service 06-16-05 was denied by the Respondent with denial codes "W2" (Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment) and "245" (the carrier is disputing the liability of the claim or compensation of the injury. Final adjudication has not taken place). The Respondent made a payment of \$27.53 and subsequently denied the remaining 4 units with denial codes "W4" (no additional reimbursement allowed after review of appeal/reconsideration), "W1" (Workers Compensation State Fee Schedule Adjustment), "891" (the insurance company is reducing or denying payment after reconsidering a bill) and "892" (denied in accordance with TWCC Rules and /or Medical Fee Guideline). It was determined at a Contested Case Hearing held on 10-10-05 that the claimant sustained a compensable low back injury during the course and scope of employment on [redacted]. The Requestor billed with diagnosis code of 846.0 and treated the lumbosacral sprain/strain. Per Rule 134.202(d)(2) additional reimbursement is recommended in the amount of **\$110.12 (\$27.53 X 4)**.

CPT code 95831-59 (4 units) billed for date of service 07-21-05 was denied by the Respondent with denial codes "W2" (Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment), "245" (the carrier is disputing the liability of the claim or compensation of the injury. Final adjudication has not taken place). The Respondent made a payment of \$33.06 and denied the remaining portion billed in dispute with denial codes "143/420" (portion of payment deferred/supplemental payment). It was determined at a Contested Case Hearing held on [redacted].

10-10-05 that the claimant sustained a compensable low back injury during the course and scope of employment on \_\_\_\_\_. The Requestor billed with diagnosis code of 846.0 and treated the lumbosacral sprain/strain. Per Rule 134.202(d)(2) additional reimbursement is recommended in the amount of **\$77.06 (\$110.12 billed minus payment of \$33.06)**.

CPT code 95831-59 (4 units) billed for date of service 08-25-05 was denied by the Respondent with denial codes "W2" (Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment), "245" (the carrier is disputing the liability of the claim or compensation of the injury. Final adjudication has not taken place). The Respondent made a payment of \$27.53 for one unit and subsequently denied the three remaining units with denial codes "W4" (no additional reimbursement allowed after review of appeal/reconsideration), "W1" (Workers Compensation State Fee Schedule Adjustment), "891" (the insurance company is reducing or denying payment after reconsidering a bill) and "892" (denied in accordance with TWCC rules and/or Medical Fee Guideline). It was determined at a Contested Case Hearing held on 10-10-05 that the claimant sustained a compensable low back injury during the course and scope of employment on \_\_\_\_\_. The Requestor billed with diagnosis code of 846.0 and treated the lumbosacral sprain/strain. Additional reimbursement per Rule 134.202(d)(2) is recommended in the amount of **\$82.59 (\$110.12 billed minus payment of \$27.53)**.

Contact was made with the Requestor on 10-13-06 via telephone. Verification was made that CPT code 97024 billed for date of service 06-03-05, CPT code 97750-FC billed for date of service 07-26-05, CPT code 90801 billed for date of service 07-27-05, CPT code 98940 billed for date of service 07-27-05, CPT code 99212 billed for date of service 08-03-05 and CPT code 90806 billed for dates of service 09-06-05, 09-19-05 and 10-03-05 were paid by the Respondent. Therefore, these services are no longer in dispute.

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

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202(c)(1) and 134.202(d)(2)  
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

#### **PART VII: DIVISION FINDINGS 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 \$505.36. 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.

Order by:

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

\_\_\_\_\_  
Typed Name

10-19-06  
\_\_\_\_\_  
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**

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AMENDED

October 2, 2006

September 28, 2006

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

Re: Medical Dispute Resolution  
MRD#: M5-06-1912-01  
DWC#: \_\_\_\_\_  
Injured Employee: \_\_\_\_\_  
DOI: \_\_\_\_\_  
IRO Certificate No. IRO5317

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 Allied Multicare Centers. 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 Centers:

Therapy notes (06/03/05 – 12/09/05)

Office notes (05/20/05 – 09/20/05)

### **Clinical History:**

This 57-year-old patient felt a pop in his lower back while lifting a 350-lb air conditioning unit from the tailgate of a vehicle trunk over a chain link fence with the assistance of another man. James Graham, M.D., evaluated the patient. X-rays of the back showed no acute bony abnormalities. Dr. Graham assessed lumbosacral strain and prescribed Darvocet N, Flexeril, and a heating pad. Dr. Graham recommended physical therapy (PT). Ronald Linderman, D.C., assessed lumbar sprain, lumbar radiculitis/neuritis, and intervertebral disc syndrome. From June 3, 2005, through October 19, 2005, the patient attended 43 sessions of therapy with Dr. Linderman. The modalities consisted of chiropractic adjustment, electrical stimulation, diathermy, myofascial release, therapeutic exercises, and neuromuscular re-education. In September 2005, Les Benson, M.D., noted that the patient was on muscle relaxants, analgesics, antidiabetic, and antihypertensive medications. Dr. Benson diagnosed lumbar radiculopathy and recommended a magnetic resonance imaging (MRI) scan of the back. The patient was advised to be off work. The patient's symptoms minimally improved. On December 9, 2005, Dr. Linderman re-evaluated the patient. The severity of pain had increased since the October visit. Dr. Linderman reported that a surgery would be scheduled in January.

### **Disputed Services:**

Chiropractic manipulative treatment (98940), massage therapy (97124), therapeutic exercises (97110), neuromuscular re-education (97112), office visits (99212), and therapeutic activities (97530).

### **Explanation of Findings:**

It appears that the employee injured himself on \_\_\_\_\_. The employee was taking medications prescribed by James Graham, MD. This did not appear to provide sufficient benefit so he changed treatment to Ronald Linderman, DC on 06/03/2005. It appears that Dr. Linderman treated the employee with passive physical modalities through 06/17/2005. Then, a course of activity based therapies was initiated on 06/20/2005 and continued through about 10/02/2005. On 12/09/2005, the chart notation indicated that the employee was scheduled for surgery.

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

Partial Uphold

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

Based on the documentation from the provider, there was little evidence of any therapeutic benefit from the extensive course of treatment to support ongoing care beyond 07/05/2005. That allows 4 weeks of chiropractic care as a reasonable trial period. This is consistent with Mercy guidelines, Occupational Medicine Practice Guidelines from the ACOEM, and ODG. In addition, the documentation inadequately defined the supervised 1:1 physical therapy provided or the requirement for the extensive 1:1 supervised care. There was no evidence in the records that the employee had cognitive dysfunction that would limit his understanding of or the need for exercising on an intensive 1:1 basis when there are less intensive options. There were no exercise logs in the records provided that outlined the alleged supervised 1:1 exercises.

In conclusion, a trial of treatment was reasonable from 06/03/2005 through 07/05/2005. Without significant therapeutic improvement from the treatment provided, the employee should be assessed at maximum therapeutic benefit for that treatment option. Chiropractic treatment beyond 07/05/2005 is not supported as a reasonably required treatment option inclusive of 98940 and 97124. There was inadequate documentation of the supervised 1:1 therapeutic exercises (97110), neuromuscular re-education (97112), and therapeutic activities (97530) to support the claim throughout the documentation. Office visits (99212) on a monthly basis to monitor referrals and return to work issues would be reasonable for the treating doctor until certified at maximum medical improvement. Therefore, office visits (99212) and massage therapy (97124) was reasonable from 06/03/2005 through 07/05/2005. CPT codes 97110, 97112, and 97530 were not supported with adequate documentation of the services provided to support the claim throughout the documentation from 06/20/2005 through 10/02/2005.

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The physician providing this review is a doctor of chiropractic. The reviewer is national board certified in chiropractic. The reviewer has been in active practice for over 22 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.