



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:
Wm. J. Kowalski, D.C.
12655 Woodforest Blvd # 200
Houston, Texas 77015

MDR Tracking No.: M5-07-0227-01 (current MDR #)
M4-06-6605-01 (former MDR #)

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

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: Per the Table of Disputed Services "Carrier failed to pay and then refused to pay of initial care then claimed that care was not medically necessary. Since carrier paid for care after this date this does not make much sense."

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: "There is simply no medical documentation to substantiate the medical necessity for the treatments provided by Requestor. The Labor Code states that treatment must make a progress towards recovery, cure or relieve symptoms...the dispute treatments or services as they failed to provide any documentation to support the medical necessity of the medications."

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)
06-22-05	99202-21-GP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$83.35
06-22-05	72040-26-WP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$14.58

06-22-05	72100-26-WP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$14.58
06-22-05 to 07-07-05	97140-22-MP (1 unit @ \$33.94 X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$305.46
06-22-05, 06-23-05, 06-24-05 and 06-27-05	97035 (1 unit @ \$15.53 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$62.12
06-22-05, 06-23-05, 06-24-05 and 06-27-05	97014 (see note below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$14.56
	Note: Reimbursement is per Rule 134.202(c)(6). Although the code is not valid for Medicare per Rule 134.202(a)(4) the code is allowed. The IRO reviewer determined that the service was medically necessary and per Rule 133.308(p)(5) the decision is a Division decision.		

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-23-05, 06-24-05, 06-30-05, 07-05-05, 07-06-05 and 07-07-05	99211 (\$27.49 X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$164.94
06-27-05 and 06-29-05	99213-21-GP (\$67.20 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$134.40
06-27-05	97012 (1 unit @ \$18.90)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$18.90
06-27-05	99080-73-RP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
06-30-05, 07-05-05, 07-06-05 and 07-07-05	97530-25-51 (1 unit @ \$37.78 X 8 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$302.24
	TOTAL DUE		\$1,130.13

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.

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 10-31-06, 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.

Date of service 02-15-05 listed on the Table of Disputed Services was per Rule 133.308(e)(1) not timely filed and will therefore not be a part of the review.

CPT code 99080-73-RP billed for date of service 07-08-05 was denied by the Respondent as "unnecessary treatment without peer review." The DWC 73 is a required report and the Medical Dispute Resolution has jurisdiction in the matter. Reimbursement per Rule 129.5(i) is recommended in the amount of **\$15.00**.

Note: The Requestor has billed several services with improper modifiers including 99202-21-GP, 97140-22-MP, 99213-21-GP and 97530-25-51, therefore, the Requestor is billed for inappropriate use of modifiers.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.308(p)(5), 134.1, 134.202(a)(4), 134.202(b), 134.202(c)(1), 134.202(c)(6) and 129.5(i)

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 \$1,145.13. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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

11-30-06

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**

Amended
November 17, 2006

November 15, 2006

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

Re: Medical Dispute Resolution
MDR#: M5-07-0227-01
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 Walter Sassard, M.D., W. M. Kowalski, D.C., and Down Stanford, P.C. 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 Walter Sassard, M.D.:

Office note (12/07/05)
Radiodiagnostic study (11/09/05)

Information provided by W. M. Kowalski, D.C.:

Office notes (06/22/05 - 11/06/06)
Chiropractic therapy (06/22/05 - 08/03/05)
Independent medical evaluation (10/20/05)
Radiodiagnostic study (11/09/05)
FCE (08/11/05 and 10/26/05)

Information provided by Down Stanford, P.C.:

Office notes (06/22/05 – 08/22/05)
Chiropractic therapy (06/22/05 – 08/08/05)
FCE (08/11/05)
Radiodiagnostic study (11/09/05)
Independent medical evaluation (12/30/05 – 02/22/06)

Clinical History:

This 72-year-old male twisted his lower back and neck while attempting to grab a heavy beam that fell out of his hands. William Kowalski, D.C., obtained x-rays that revealed flattened lumbar lordosis and cervical spondylosis. Dr. Kowalski assessed lumbar radiculitis and cervical and lumbar strain, and initiated therapy. From June through September, the patient attended 24 sessions of therapy consisting of electrical muscle stimulation (EMS), spinal manipulation, spinal adjustments, ultrasound, myofascial release, intersegmental traction, hot packs, and therapeutic exercises. A history of a right rotator cuff repair in 1990 and to the left shoulder in 1992 and arthritis of hands was noted. The patient's medications were Nexium, Aerobid, Xopenex, Singulair, Ultracet, Celebrex, and Proventil.

He attended 10 sessions of a work conditioning program (WCP) following a functional capacity evaluation (FCE). William Green, M.D., a designated doctor, deferred the assessment of maximum medical improvement (MMI) and recommended an orthopedic consultation. Magnetic resonance imaging (MRI) revealed disc disease with 2-3 mm diffuse protrusions involving the L3-L4, L4-L5, and L5-S1 levels, with mild neuroforaminal narrowing at L3-4 and L4-5. X-rays showed moderate osteophyte formation at L3 and L4. Walter Sassard, M.D., an orthopedic surgeon, felt that the diffuse protrusions were within the accepted physiologic normal for this age and did not represent posttraumatic herniations. He suggested conservative treatment with exercises and good body mechanics.

A peer reviewer, Leslie Miner, D.C., indicated that no further chiropractic care was medically necessary after August 16, 2005, as the injury had resolved without evidence of any neurological findings. The patient's condition had remained unchanged since the FCE in August. Dr. Miner added that no further treatment, diagnostic tests, durable medical equipment (DME), WCP/WHP would be medically necessary. MRI suggested spondylosis with an element of pre-existing degenerative changes in the lumbar spine, and therefore, was related to a disease of life. The shoulder surgeries were not related to the occupational injury of June 2005.

Dr. Kowalski assessed clinical maximum medical improvement (MMI) as of February 15, 2006, and assigned 5% whole person impairment (WPI) rating. On November 6, 2006, Dr. Kowalski noted that the carrier had refused to pay for initial medical treatment, evaluation, x-rays, and had also refused to pay for impairment rating (IR) as the treatment in dispute had not met any of the criteria. There was no medical documentation to substantiate the medical necessity for the treatments provided by Dr. Kowalski.

Disputed Services:

X-rays of neck/spine (72040-26-WP), x-rays of lower spine (72100-26-WP), manual therapy (97140-22-MP), ultrasound (97035), therapeutic activities (97530-25-51), mechanical traction (97012), unattended electrical stimulation (97014), required report (99080-73-RP) and office visits (99211), 99213-GP and 99202-21-GP. Dates of service (06/22/05 through 07/07/05) - mixed dispute.

Explanation of Findings:

Based on review of available medical records, Mr. ___ sustained a work-related injury to his cervical and lumbar spine on ___. The following day he was evaluated, x-rayed and began a treatment regimen with chiropractor, Dr. William Kowalski. From 6/22/05 to 6/27/05 treatment consisted of manual therapy (manipulation/adjustment) and 1-2 passive modalities, during which time Mr. ___ was on off work status. He was released to RTW light duty on 6/27/05, consisting of 4hrs/day of sitting/standing, no lifting over 10 lbs, and stretch breaks every hr. From 6/29/05 to 7/7/05 treatment consisted of manual therapy and therapeutic activities, during which time records reveal that there was a gradual increase in the amount of weight/resistance on the equipment, along with an increase in the number of repetitions performed. Subsequently his light duty work restrictions were modified to 8hrs/day of walking/climbing/reaching, with no lifting over 20-25 lbs, to be effective on 7/12/05.

Given Mr. ___'s stated age, history of trauma, with pain and limitation of motion, x-rays of the cervical and lumbar spine are reasonable and considered to be within the ordinary standards of care to evaluate the vertebrae, disc spaces, bony neural foramina, and paravertebral soft tissues, in order to identify or rule-out abnormalities or disease processes of the spine. An initial 3-4 week trial of the type and scope of treatment rendered is supported by peer-reviewed and evidence-based treatment guidelines. Treatment consisting of manual therapy (manipulation), the above referenced passive modalities and therapeutic activities, along w/ minimal office visit services, during the disputed dates of service (6/22/05 through 7/7/05) are documented to have been effective in relieving the effects of the reported injury, and promoting a level of functional

recovery that enhanced the ability of the employee to return to employment. It should also be noted that completion of Work Status reports is required by Texas Workers' Compensation Rules and Regulations.

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

Overturn denial

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

X-rays on 6/22/05 are supported by American College of Radiology, Spine Radiography, 2003. A trial of treatment, of the type and scope documented, is supported by ACOEM Guidelines, Chapter 8, Pages 173-175 and Chapter 12, Pages 298-300, and was noted to have been effective between 6/22/05 and 7/8/05 in accordance with Texas Labor Code 408.021. Work Status reports are required by Texas Workers' Compensation Rules and Regulations.

The physician providing this review is a Chiropractor. The reviewer is national board certified in Chiropractic. The reviewer is a member of the Texas Chiropractic Association, Diplomate of the American Academy of Pain Management, Diplomate of the American Board of Disability Analysts, and Board Eligible in Chiropractic Orthopedics. The reviewer has been in active practice for 20 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, 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.