

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-05-4513.M5

MDR Tracking Number: M5-05-0140-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution – General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 9-8-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The manual therapy, mechanical traction, stimulation, chiropractic manipulation, therapeutic procedure and office visits from 10-20-03 through 1-30-04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 10-08-04 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.

Regarding CPT Code 97110 for 10-20-03, 10-21-03, 10-22-03, 10-24-03, 10-27-03, 10-29-03 and 10-31-03: Neither the requestor nor the respondent submitted EOB's or the Carrier denied these services with a "D" - The provider has billed for these exact services on a previous bill. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

Regarding CPT code 99212 on 1-19-04: The carrier denied this service with N – not appropriately documented. The requester submitted no additional information to support the level of service billed. **Recommend no reimbursement.**

Neither the carrier nor the requestor provided EOB's for CPT code 98940 on 12-29-03. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$30.14 MAR.**

Neither the carrier nor the requestor provided EOB's for CPT code 97140 on 10-24-03. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$30.90 MAR.**

CPT Code 99213 on 11-24-03 and 12-03-03 was denied with Y/JM – The code and/or modifier is invalid. However, this is a valid code according to the Medical Fee Guidelines and no modifier was utilized. Pursuant to Rule 133.304(c) "The explanation of benefits shall include the correct payments exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." **Recommend reimbursement of \$118.00 (\$59.00 MAR x 2 DOS).**

This Finding and Decision is hereby issued on January 27, 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 10-20-03 through 1-30-03 as outlined above in this dispute.

This Order is hereby issued on January 27, 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

October 27, 2004

TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___

EMPLOYEE: ___

POLICY: M5-05-0140-01

CLIENT TRACKING NUMBER: M5-05-0140-01 5278

AMMENDED REVIEW - 12/15/04

Medical Review Institute of America (MRloA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRloA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRloA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRloA for independent review.

Records Received:

Records from the State:

Notification of IRO Assignment, 10/8/04

MR-117 TWCC Notification. 10/8/04

Medical Dispute Resolution Request/Response form, 9/8/04

Table of Disputed Services

Explanation of Benefits forms

Claim Vendor/Payee reports

Records from James Tanner, DC

Retrospective Review Information Request, 10/12/04

(continued)

Request for Reconsideration, 6/23/04
Radiology report, Hauser Radiology Associates, 9/24/03
Radiology report, Corpus Christi MRI Center, 9/30/04
Initial Narrative report, James Tanner, DC, 9/12/03
Progress report, James Tanner, DC, 10/10/03
Office notes, James Tanner, DC, 12/3/03, 12/9/03, and 12/29/03
Daily Patient notes, James Tanner, DC, 9/15/03 through 2/6/04
History and Physical, Thomas Edwards, MD, 1/5/04
Operative report, Thomas Edwards, MD, 1/13/04
SOAP notes, MedWorks, 2/20/04

Summary of Treatment/Case History:

Patient had a low back injury that involved radicular type pain into the lower extremity. Reduced ranges of motion in the lumbar, + Valsalva, + toe walk, + bilateral Kemps, reduced tendon reflexes of the patellar and Achilles, and reduced dermatomal response (hypoesthesia) for L4, L5 and S1.

Questions for Review:

The dates of service in question are from 10/20/03 – 1/30/04:

1. Please advise medical necessity of manual therapy (#97140), mechanical traction (#97012), stimulation (#G0283), chiropractic manipulation (#98940), therapeutic procedure (#97110), office visit (#99212), and office visit (#99213).

Explanation of Findings:

The treatment for the patient ___ began on 9/15/04. These treatments included modalities inside the scope of practice for the doctor James Tanner, DC. The treatments included chiropractic adjustments, electrical muscle stimulation, ice applied to the injured area, exercises and stretching. There are three stages of care in treatment, active care, which can last up to 6–8 weeks, rehabilitative care dependant on diagnosis and findings, and then maintenance care. During the active care stage of treatment to the patient James Thompson, the doctor utilized reasonable and medically necessary modalities to the patient. When the patient did not respond as rapidly as expected, additional diagnostic tests were ordered in the way of MRI. The findings on the MRI were supportive in both the diagnosis and delivered care of this patient. MRI findings revealed a L4–L5 herniation.

Conclusion/Decision to Certify:

1. Please advise medical necessity of manual therapy (#97140), mechanical traction (#97012), stimulation (#G0283), chiropractic manipulation (#98940), therapeutic procedure (#97110), office visit (#99212), and office visit (#99213).

The decision is to certify as medically necessary the care given to patient ____ by James Tanner DC.

James Tanner was working within the expected protocol for a reasonably prudent and conservative treatment plan considering the patient diagnosis. The utilization was both within the expected guidelines and appropriate time frame regarding this patient's injuries, and was medically necessary.

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

There are three phases regarding care, the first phase is known as the active care stage, this is where the care consists of physical modalities such as chiropractic adjustments, ice, electrical stimulation, exercises, stretching etc. Basically, this is the stage where there is inflammation, pain and tissue injury/changes. This stage typically lasts for 6 to 8 weeks, and its goal is to reduce immediate tissue injury and increase patient comfort. Following the active phase of care, is the rehabilitative phase whose time length is dependant on the diagnosis, on the amount of tissue injury, on the tissue involved co-morbidities and on other factors. The time to the return to a pre-injury stage varies greatly. The maintenance stage is the last stage, and mostly involves strengthening and maintaining any corrective changes.

Active care, which may include manipulative therapy, modalities and strengthening exercises, is considered to be 6 –8 weeks in time. In most cases excellent response symptomatically can be expected in 75% of cases with 19 visits within a 43-day period (Soft Tissue and Rheumatic Pain, Recognition. Management.prevention, page 196). If noted improvement is not documented, further studies and interventions are necessary, both of which Dr. Tanner followed in a timely manner.

References Used in Support of Decision:

Rehabilitation of the Spine – Crain Liebenson

Soft Tissue and Rheumatic Pain, Recognition,Management,prevention – Sheon,Moskowitz,Goldberg

Practical Orthopedics – Mercier

The physician providing this review is board certified in chiropractic medicine. The reviewer also holds additional certifications in Acupuncture and Orthopedics. The reviewer is a member of their state chiropractic association and is certified to provide reviews for the workers compensation commission as a designated doctor, RME and IME. The reviewer has been in active practice since 1998.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

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

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The written opinions provided by MRIOA 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 MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America 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 agrees to hold MRIOA harmless for any and all claims which may arise as a result of 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.

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