

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, 133.307 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. This dispute was received on 12-07-04.

The IRO reviewed therapeutic exercises, manual therapy, electrical stimulation, hot/cold packs, level II and IV office visits, chiropractic manipulation spinal 1-2 regions and level I office visits rendered from 03-05-04 through 06-24-04 that were denied based upon "V".

The IRO determined that the active and passive care (excluding spinal manipulation) from 03-05-04 through 04-28-04 **was** medically necessary. The IRO determined that chiropractic intervention, office visits and physical therapy beyond 04-28-04 **was not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of 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.

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 the Medical Review Division.

On 02-01-05, 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 97010 dates of service 03-29-04, 04-21-04 and 04-26-04 denied with denial code "G/B377 (bundled procedure, no separate payment allowed). In accordance with the 2002 Medical Fee Guideline hot/cold pack application is a bundled service code and considered an integral part of a therapeutic procedure(s). Payment is included in the allowance for another therapy service/procedure performed. No reimbursement is recommended.

CPT code 97750-FC date of service 04-08-04 denied with denial code "F/Z560" (the charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix). The carrier has made a payment of \$411.60 per the EOB submitted. The MAR per Rule 134.202(b) (c)(1) is \$411.60 ($\$27.44 \times 125\% = \34.30×12 units billed). Payment was verified with the requestor. No additional reimbursement is recommended.

This Findings and Decision is hereby issued this 7th day of March 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the Medicare program reimbursement methodologies effective 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 03-05-04 through 04-26-04 in this dispute.

This Order is hereby issued this 7th day of March 2005.

Margaret Ojeda, Manager
Medical Dispute Resolution
Medical Review Division

MQO/dlh

Enclosure: IRO Decision

INITIAL COMPLETION DATE: JANUARY 18, 2005
AMENDED COMPLETION DATE: JANUARY 31, 2005

BENITA DIAZ
TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M5-05-109901
CLIENT TRACKING NUMBER: M5-05-109901 5278

AMENDED REVIEW

Medical Review Institute of America (MRIOA) 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 MRIOA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA 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 MRIOA for independent review.

Records Received:

Records Received from the State:

Notification of IRO assignment dated 12/21/04, 1 page

Letter from TWCC dated 12/21/04, 1 page

Medical dispute resolution request/response, receipt from requestor date 12/7/04, 8 pages

EOB forms for dates of service 3/5/04 through 6/24/04, 21 pages

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Records Received from Matthew Higgs, DC:

Request for reconsideration dated 8/27/04, 2 pages
Letter from Dr. Buck dated 3/21/04, 5 pages
Concurrent review dated 2/25/04, 3 pages
TWCC-69 report of medical evaluation dated 6/23/04, 1 page
Report of impairment rating evaluation dated 6/23/04, 6 pages
Letter from Wausau dated 6/16/04, 1 page
Letter from Wausau dated 5/5/04, 1 page
Functional capacity evaluation summary dated 5/25/04, 18 pages
FCE evaluation dated 4/8/04, 3 pages
Functional capacity evaluation informed consent dated 4/8/04, 1 page
Short screening for anxiety and depression dated 4/8/04, 1 page
Progressive Diagnostics report dated 5/18/04, 7 pages
Progressive Diagnostics report dated 4/19/04, 7 pages
Progressive Diagnostics report dated 2/9/04, 7 pages
Prescription and statement of medical necessity dated 5/18/04, 1 page
Prescription and statement of medical necessity dated 4/19/04, 1 page
MRI report dated 3/8/04, 1 page
Left shoulder x-ray report dated 2/7/04, 1 page
Office report dated 3/5/04, 4 pages
Office report dated 3/24/04, 8 pages
Office report dated 4/21/04, 3 pages
Office report dated 5/24/04, 2 pages
Office report dated 6/14/04, 2 pages
Office report dated 6/24/04, 1 page

Summary of Treatment/Case History:

According to the submitted documentation, the patient injured his left shoulder from moving packages on a top shelf at . The patient began chiropractic intervention with the current provider, Matthew Higgs, D.C., on 2/6/04. The patient attended daily treatment sessions for approximately two weeks, then was placed on three times per week. The provider utilized both active and passive modalities and exercises.

A peer review was done on 2/25/04 recommending 12 active care sessions and 9 passive care sections through 3/19/04. On 3/8/04 a left shoulder MRI revealed the following: mild to moderate supraspinatus tendinopathy and Peritendinitis with an intrasubstance partial thickness tear, along with mild hypertrophic acromioclavicular joint arthropathy. Work conditioning appears to have begun in early 5/04.

The 3/31/04 RME recommended current treatment at that time and also work conditioning. Ten work conditioning sessions were preauthorized and approved on 5/5/04 and 6/16/04, for a total of 20 sessions.

There appears to have been a gap in treatment between 4/28/04 and 5/24/04.

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In 6/04 two spinal manipulations appear to have been conducted.

Questions for Review:

The dates of service in dispute are 3/5/04 through 6/24/04. The items in dispute include therapeutic exercises #97110, manual therapy #97140, electrical stimulation #97032, hot/cold packs #97010, level 2 and 4 office visits #99212 and #99214, chiropractic manipulation spinal 1-2 regions #98940, and level 1 office visit #99211. Please address medical necessity.

Explanation of Findings:

The dates of service in dispute are 3/5/04 through 6/24/04. The items in dispute include therapeutic exercises #97110, manual therapy #97140, electrical stimulation #97032, hot/cold packs #97010, level 2 and 4 office visits #99212 and #99214, chiropractic manipulation spinal 1-2 regions #98940, and level 1 office visit #99211. Please address medical necessity.

The previous review was done on 2/25/04. The MRI was performed on 3/8/04. The MRI revealed mild to moderate supraspinatus tendinopathy and peritendinitis, with an intrasubstance partial thickness tear, and mild hypertrophic joint arthropathy. The severity of the condition was revealed and confirmed by this MRI, and the additional treatments were considered to be medically necessary. The insurance company preauthorized 20 sessions of work conditioning beginning in 5/04. Treatments prior to 5/04 were mainly active treatment sessions which brought the patient to a physical demand level appropriate for beginning work conditioning. The active care sessions would also allow the work conditioning to bring the patient to the physical demand level required by his employer in a reasonable and necessary amount of time.

Medical necessity is defined as a test or procedure that is reasonable and necessary for the diagnoses or treatment of an illness or injury.

Based on the current available documentation, particularly the results of the MRI and RME, the active and passive care documented above (excluding spinal manipulations) from 3/5/04 through 4/28/04 is medically necessary.

Conservative treatment including chiropractic intervention, office visits, and physical therapy beyond 4/28/04 is not medically necessary.

The spinal manipulations prior to 4/28/04 are not medically necessary. Services beyond 4/28/04 are deemed not medically necessary; therefore, the spinal manipulations in 6/04 are not medically necessary.

Medical necessity has not been established for spinal manipulations in this case.

Conclusion/Partial Decision to Certify:

Medical necessity is defined as a test or procedure that is reasonable and necessary for the diagnoses or treatment of an illness or injury.

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Based on the current available documentation, particularly the results of the MRI and RME, the active and passive care documented above (excluding spinal manipulations) from 3/5/04 through 4/28/04 is medically necessary.

Conservative treatment including chiropractic intervention, office visits, and physical therapy beyond 4/28/04 are not medically necessary.

The spinal manipulations prior to 4/28/04 are not medically necessary. Services beyond 4/28/04 are deemed not medically necessary; therefore, the spinal manipulations in 6/04 are not medically necessary.

Medical necessity has not been established for spinal manipulations in this case.

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

The Milliman Care Guidelines

The Cochrane Library, Hayes Inc.

References Used in Support of Decision:

Guidelines for Chiropractic Quality Assurance and Practice Parameters, (Mercy Guidelines)

The physician providing this review is a Doctor of Chiropractic. The reviewer is national board certified in Physiotherapy and is certified in Acupuncture. The reviewer is a member of the American Academy of Disability Evaluating Physicians (AADEP) and is on the approved doctor list for the Texas Worker's Compensation Commission. The reviewer has been in active practice for 12 years.

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 MRloA 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.

The written opinions provided by MRloA 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 MRloA 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

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authorizing this case review agrees to hold MRloA 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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