

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 02-01-05.

The IRO reviewed therapeutic exercises (97110), office visits (99211-25-subsequent visits), mechanical traction (97012), chiropractic manual treatment-spinal (98940), therapeutic procedures (97150), massage therapy (97124), office visits (99213-25 and 99212-25) rendered from 03-31-04 through 07-23-04 that were denied based upon "V".

The IRO concluded that mechanical traction (97012), chiropractic manual treatment-spinal (98940), therapeutic procedures (97150), massage therapy (97124) and office visits (codes 99211 and 99212-25) one or the other every four weeks, not both and not more in frequency **were** medically necessary. The IRO further concluded that the therapeutic exercises (97110), office visits (99213-25) and excessive billings of office visits (99211 and 99212-25) **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$481.68**.

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 03-10-05, 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 97139-EU dates of service 02-03-04, 02-04-04 and 02-05-04 will not be a part of the review as this modifier is invalid.

CPT code 97750-MT dates of service 04-02-04, 06-15-04, 07-02-04, 07-28-04 and 08-03-04 will not be a part of the review as this code is invalid for Medicare.

CPT code 99070 dates of service 01-27-04, 02-02-04 and 03-03-04 denied with denial code "M" (no MAR). The carrier has made a payment of \$47.18, \$29.75 and \$24.23 respectively. Per Rule 134.202(d)(2) "reimbursement shall be the least of the: health care provider's usual and customary charge". The requestor did not submit documentation to support their usual and customary charge for CPT code 99070. No additional reimbursement recommended.

CPT code 99213-25 date of service 01-30-04 denied with denial code "G/509" (unbundling/correct coding initiative bundle guidelines indicate this code is a comprehensive component of another code on the same day). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code 99213-25 was global to. Reimbursement per Rule 134.202(c)(1) is \$61.98 (49.58 X 125%). The requestor billed \$58.99, therefore, reimbursement is recommended in the amount of **\$58.99**.

CPT code 97124 date of service 01-30-04, 02-02-04, 02-25-04, 03-01-04, 03-03-04, 03-08-04, 03-31-04, 06-17-04, 06-18-04, 06-21-04, 06-23-04 and 06-25-04 denied with denial code "G/509" (unbundling/correct coding initiative bundle guidelines indicate this code is a comprehensive component of another code on the same day). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code 97124 was global to. Reimbursement per Rule 134.202(c)(1) is \$26.28 (\$21.02 X 125%) per date of service. The requestor billed \$25.69 per date of service. Reimbursement is recommended in the amount of **\$308.28 (\$25.69 X 12 DOS)**.

CPT code 99212-25 date of service 02-02-04, 02-25-04, 02-27-04 and 05-05-04 denied with either denial code "G/509" (unbundling/correct coding initiative bundle guidelines indicate this code is a comprehensive component of another code on the same day) or denial code "G/210" (unbundling/ the visit has been included in the treatment performed). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code 99212-25 was global to. Reimbursement per Rule 134.202(c)(1) is \$44.16 (\$35.33 X 125%). The requestor billed \$41.91 for each date of service. Reimbursement is recommended in the amount of **\$167.64 (\$41.91 X 4 DOS)**.

Review of CPT code 97012 dates of service 02-03-04, 02-04-04 and 02-05-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence that the carrier was in receipt of the providers request for EOBs. Reimbursement per Rule 134.202(c)(1) is \$17.91 (\$14.33 X 125%). The requestor billed \$17.20 for each date of service. Reimbursement is recommended in the amount of **\$51.60**.

Review of CPT code 98940 dates of service 02-03-04, 02-04-04 and 02-05-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence that the carrier was in receipt of the providers request for EOBs. Reimbursement per Rule 134.202(c)(1) is \$31.35 (\$25.08 X 125%). The requestor billed \$30.13. Reimbursement is recommended in the amount of **\$90.39 (\$30.13 X 3 DOS)**.

Review of CPT code 97024 date of service 02-03-04 revealed that neither party submitted a copy of the EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence that the carrier was in receipt of the providers request for an EOB. Reimbursement per Rule 134.202(c)(1) is \$6.99 (\$5.59 X 125%). The requestor billed \$5.53, therefore reimbursement is recommended in the amount of **\$5.53**.

Review of CPT code 97124 dates of service 02-03-04 and 02-04-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence that the carrier was in receipt of the providers request for EOBs. Reimbursement per Rule 134.202 (c)(1) is \$26.28 (\$21.01 X 125%). The requestor billed \$25.69. Reimbursement is recommended in the amount of **\$51.38 (\$25.69 X 2 DOS).**

Review of CPT code 99212-25 date of service 02-04-04 revealed that neither party submitted a copy of the EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence that the carrier was in receipt of the providers request for an EOB. Reimbursement per Rule 134.202 (c)(1) is \$44.16 (\$35.33 X 125%). The requestor billed \$41.91 therefore reimbursement is recommended in the amount of **\$41.91.**

Review of CPT code 97110 dates of service 02-04-04 and 02-05-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence that the carrier was in receipt of the providers request for EOBs, however, recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. No reimbursement is recommended.

CPT code 97110 dates of service 02-25-04, 02-27-04, 03-01-04, 03-03-04, 03-08-04, 06-18-04 denied with denial code "G/509" (unbundling/correct coding initiative bundle guidelines indicate this code is a comprehensive component of another code on the same day). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code 99213-25 was global to, however, recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. No reimbursement is recommended.

CPT code 97110 date of service 06-17-04 denied with denial code "F/663" (Fee Guideline MAR reduction/reimbursement has been calculated according to State Fee Schedule Guidelines). Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. No reimbursement is recommended.

Review of CPT code 97150 dates of service 02-04-04 and 02-05-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence that the carrier was in receipt of the providers request for EOBs. Reimbursement per Rule 134.202 (c)(1) is recommended in the amount of **\$41.96 (\$16.78 X 125% = \$20.98 X 2 DOS)**.

Review of CPT code 99211-25 date of service 02-05-04 revealed that neither party submitted a copy of the EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence that the carrier was in receipt of the providers request for an EOB. Reimbursement per Rule 134.202 (c)(1) is \$24.44 (\$19.55 X 125%). The requestor billed \$23.35 therefore reimbursement is recommended in the amount of **\$23.35**.

CPT code 99070 date of service 02-05-04 denied with denial code "F/855-002" (Fee Guideline MAR reduction/recommended allowance is in accordance with workers compensation medical fee schedule guidelines). The carrier has made a payment of \$24.23. Per Rule 134.202(d)(2) "reimbursement shall be the least of the: health care provider's usual and customary charge". The requestor did not submit documentation to support their usual and customary charge for CPT code 99070. No additional reimbursement recommended.

CPT code 95851 date of service 02-19-04 denied with denial code "F/663" (Fee Guideline MAR reduction/reimbursement has been calculated according to State Fee Schedule Guidelines). The carrier has made a payment of \$23.15. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation to support delivery of service. Per Rule 134.202(c)(1) reimbursement is \$23.15 (\$18.52 X 125%). No additional reimbursement is recommended.

CPT code 99211-25 dates of service 03-01-04, 06-17-04, 06-21-04 and 06-29-04 denied with denial code "G/210" (unbundling/ the visit has been included in the treatment performed). Per Rule

133.304(c) and 134.202(a)(4) the carrier did not specify which service code 99211-25 was global to. Per Rule 134.202(c)(1) reimbursement is \$24.44 (\$19.55 X 125%). The requestor billed \$23.35. Reimbursement is recommended in the amount of **\$93.40 (\$23.35 X 4 DOS)**.

CPT code 99080 date of service 04-07-04 denied with denial code "F/663" (Fee Guideline MAR reduction/reimbursement has been calculated according to State Fee Schedule Guidelines). The carrier has made a payment of \$15.00. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation to support delivery of service. Additional reimbursement is recommended in the amount of **\$42.00**.

CPT code 95851 date of service 04-13-04 denied with denial code "G/450" (unbundling/when physical medicine test and measurements are billed on the same date of service as muscle testing or range of motion procedures, only the procedure with the highest value is allowed). Per Ingenix Encoder.Pro.Com code 95851 is a bundled code to code 97750-MT billed on 04-13-04. Per the EOB submitted by the carrier code 97750-MT has been reimbursed. No reimbursement is recommended.

CPT code 99212-25 dates of service 07-28-04 and 08-02-04 denied with denial code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement per Rule 134.202(c)(1) is \$44.16 (\$35.33 X 125%). The requestor billed \$41.91. Reimbursement is recommended in the amount of **\$83.82 (\$41.91 X 2 DOS)**.

CPT code 98940 dates of service 07-28-04 and 08-02-04 denied with denial code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement per Rule 134.202(c)(1) is \$31.35 (\$25.08 X 125%). The requestor billed \$30.13. Reimbursement is recommended in the amount of **\$60.26 (\$30.13 X 2 DOS)**.

CPT code 97012 date of service 08-02-04 denied with denial code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement per Rule 134.202(c)(1) is \$17.91 (\$14.33 X 125%). The requestor billed \$17.20, therefore, reimbursement is recommended in the amount of **\$17.20**.

CPT code 97110 date of service 08-02-04 denied with denial code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses, however, recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. No reimbursement is recommended.

CPT code 97150 date of service 08-02-04 denied with denial code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$20.98 (\$16.78 X 125%)**.

CPT code 97124 date of service 08-02-04 denied with denial code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement per Rule 134.202(c)(1) is \$26.28 (\$21.02 X 125%). The requestor billed \$25.69, therefore, the recommended reimbursement is **\$25.69**.

CPT code 99213 date of service 08-03-04 denied with denial code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement per Rule 134.202(c)(1) is \$61.98. The requestor billed \$58.99, therefore, the recommended reimbursement is **\$58.99**.

CPT code 95851 date of service 08-03-04 denied with denial code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$23.15 (\$18.52 X 125%)**.

CPT code 99212 date of service 08-05-04 denied with code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement per Rule 134.202(c)(1) is \$44.16 (\$35.33 X 125%). The requestor billed \$41.91. Reimbursement is recommended in the amount of **\$41.91**.

CPT code 99080-73 date of service 08-05-04 denied with code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement per Rule 129.5(i) is recommended in the amount of **\$15.00**.

CPT code 99211 date of service 08-06-04 denied with code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement per Rule 134.202(c)(1) is \$24.44 (\$19.55 X 125%). The requestor billed \$23.35, therefore, the recommended reimbursement is **\$23.35**.

HCPCS code A9300-5134 date of service 08-06-04 denied with code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement is recommended in the amount of **\$48.00**.

HCPCS code A9300 date of service 08-06-04 denied with code "R/880-125" (Extent of injury/denied per insurance non-covered procedure or service). The carrier did not dispute extent of injury regarding the lumbar injury, rather, disputed any and all psychological problems per the TWCC-21 on file. The diagnoses billed did not include any or all psychological diagnoses. Reimbursement is recommended in the amount of **\$32.00**.

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 for dates of service 01-30-04 through 08-06-04 totaling \$1,908.46 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 Findings and Decision and Order are hereby issued this 9th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

ORIGINAL REVIEW COMPLETION DATE: MARCH 21, 2005
AMENDED REVIEW COMPLETION DATE: MARCH 26, 2005

ROSALINDA LOPEZ/ GLORIA C
TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT:
EMPLOYEE:
POLICY: M5-05-1590-01 /
CLIENT TRACKING NUMBER: M5-05-1590-01/5278

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 3/10/05, 2 pages

Medical dispute resolution request/response, date stamp for receipt from requestor 2/1/05, 4 pages

Explanation of review for services 3/31/04 through 7/23/04, 4 pages

Records Received from the Requestor:

Some medical evidence relied upon to form basis of medical opinions, undated, 14 pages

Annotated bibliography 2004, 9 pages

TCA quality standards for opinions based upon paper review dated 11/23/04, 4 pages

Appendix D, undated, 3 pages

Evidence for Dr. Bailey's opinion on use of CPT code #97110, undated, 3 pages

Patient office visit reports dated 1/27/04 through 8/6/04, 48 pages

Subsequent medical narrative report dated 4/13/04, 9 pages

Lumbar range of motion assessment report dated 4/13/04, 1 page

Texas Workers' Compensation work status report dated 4/15/04, 1 page

MRI of the lumbar spine dated 3/8/04, 1 page

Workers' Compensation narrative report dated 3/16/04, 3 pages

Electromyography report dated 3/16/04, 1 page

Subsequent medical narrative report dated 8/3/04, 8 pages

Texas Workers' Compensation work status report dated 8/5/04, 1 page

Lumbar range of motion assessment report dated 8/3/04, 1 page

Special testing report for dates of service 2/23/04 through 7/28/04, 2 pages

DeLorme testing report for dates of service 2/23/04 through 7/28/04, 1 page

Therapeutic procedures charts dated 2/4/04 through 8/2/04, 16 pages

Treatment plans dated 2/2/04 through 6/18/04, 4 pages

Exercise grids dated 2/4/04 through 8/2/04, 12 pages

Orthopedic consult dated 4/19/04, 2 pages

Letter from Kimberlee Stukenbrock dated 5/20/04, 1 page

Letter from Concentra Integrated Services, Inc dated 7/8/04, 1 page

Summary of Treatment/Case History:

The patient was treated from 1/27/04 through 8/6/04 for an injury. The doctor's notes state that re-exams and follow-ups were completed at necessary intervals of not more than 1 time every 3 to 4 weeks; this would be an appropriate time frame for re-exams. The billing, however, reflects differently. Exams were performed on 5/5/04, 6/17/04, 6/21/04, 6/29/04, 7/5/04, 7/12/04, 7/16/04, 7/21/04, 7/23/04, 7/28/04, 8/2/04, and 8/6/04. Some of these dates are only days apart. Follow-up re-exams occurring at this rate are excessive.

Questions for Review:

The dates of service in dispute are 3/31/04 through 7/23/04. The items in dispute are #97110 (therapeutic exercises), #99211-25 (subsequent visits), #97012 (mechanical traction), #98940 (chiropractic manual TRMT-spinal), #97150 (therapeutic procedures - GRP), #97124 (massage), #99213-25 (office visit), and #99212-25 (office visit). Denied by carrier for unnecessary treatment with peer review. EBO codes "V" and "Y."

Explanation of Findings:

An exercise program to rehab weakened musculature to the spine must be performed on a reliable and constructed rehabilitation schedule. The billing for #97110 has large gaps, leading the information to the point that it was not a followed plan. On 3/31/04 6 units of exercise were billed for diagnosis code 195.00. The next group was not until 6/17/04. There is a large gap in the patient care for rehabilitative exercise.

Large gaps in time regarding therapeutic exercise and the frequency of the exams of #99211, #99212-25, and #99213-24 are evaluated as not medically necessary.

Codes #97012, #98940, #97124, #97150 are medically necessary as billed. The time frame for usage is within appropriate standards, and considered reasonable and prudent for scheduling of care.

Conclusion/Partial Decision to Certify:

Codes #97012, #98940, #97150, and #97124 are medically necessary.

Codes #99211 and #99212-25 are medically necessary, at the rate of one time per month or a four week period only. Once every four weeks code #99211 or #99212-25 would be medically necessary, one or the other every four weeks, not both and not more in frequency.

Codes #97110, #99213-25, and excessive billings (as described above) of #99211 and #99212-25 are not medically necessary.

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

Medline Plus- Soft tissue rehab
Chiropractic Manipulative Therapies - Lawrence
Chiropractic Standard for Coding and Reimbursement

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.

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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