

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 (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 2-1-05.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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

The vasopneumatic device therapy, manual therapy, therapeutic exercises, office visits, physical medicine procedure, electrical stimulation, chiropractic manipulative treatments and mechanical traction therapy from 2-9-04 through 2-23-04 **were found** to be medically necessary. The vasopneumatic device therapy, manual therapy, therapeutic exercises, office visits, physical medicine procedure, electrical stimulation, chiropractic manipulative treatments and mechanical traction therapy from 2-25-04 through 7-05-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. **The amount due the requestor for medical necessity issues totals \$297.28.**

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 3-1-05, the Medical Review Division submitted a Notice to the 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 97799 – Unlisted Physical Medicine Procedure was used for a procedure titled “decompressive disc therapy”. TWCC has determined that this is most similar to CPT code 97140 – Manual therapy technique. (Per Rule 134.202 (c) 6) “for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount, the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decision, and values assigned for services involving **similar** work and resource commitments.”) This therapy has a MAR value of \$34.13 for .

CPT Code 97140-59 on 2-3-04, 2-4-04, 2-5-04, 2-6-04, 2-10-04, 2-18-04 and 4-7-04 was denied as “23” – This procedure, which is the component code, is considered integral to the successful completion of the comprehensive procedure. The procedure does not represent a separately identifiable, unrelated procedure. Per Ingenix Encoder Pro CPT code 97140 is a mutually exclusive procedure to 97032. A modifier is allowed in order to differentiate between the services provided.

Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The requestor used the modifier "59" to show that this is a distinct procedural service. Per Rule 133.304 (c) Carrier didn't specify which service this was "integral to", therefore it will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of **\$238.91 (\$34.13 X 7 DOS)**.

Regarding CPT code 97032 on 2-3-04, 2-4-04, 2-5-04, 2-6-04, 2-9-04, 2-10-04, 2-11-04, 2-13-04, 2-16-04, 2-18-04, 2-20-04, 2-23-04, 2-25-04, 3-1-04, 3-3-04, 3-5-04, 3-10-04, 3-12-04, 3-15-04, 3-16-04, 3-18-04, 3-19-04 and 3-22-04: Neither the carrier nor the requestor provided EOB's. 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 \$464.60 (\$20.20 X 23 DOS)**.

CPT code 97799 on 3-10-04 was denied as "JF" - Documentation submitted does not substantiate the service billed. The requester submitted relevant information including a position paper and medical notes to support the Modality billed. The respondent has reimbursed \$14.86. **Recommend additional reimbursement according to the MAR for CPT code 97140 of \$19.27 (\$34.13 - \$14.86)**.

CPT code 97039-CM on 3-10-04 was denied as "UL" - An unlisted procedure or service requires identification and the amount charged substantiated "By Report". The requester submitted relevant information to support the Modality billed. **Recommend reimbursement of \$14.86**.

CPT code 97799 on 3-12-04 (2 units), 3-16-04, 3-17-04 (2 units), 3-18-04, 3-19-04 (2 units), 3-22-04 (2 units), 3-23-04 (2 units), 3-24-04 (2 units), 3-25-04 (2 units), 3-26-04 (2 units), 4-12-04 (2 units), 4-14-04 (2 units), 4-16-04 (2 units), 4-19-04 (2 units), 5-3-04 (2 units), 5-5-04 (2 units), was denied as "JM" - The code and/or modifier billed is invalid or it was denied as "NC" - The service is either not covered or the service is not recognized as a valid service. Per Ingenix Encoder Pro this is a valid code for an "Unlisted physical medicine/rehabilitation service or procedure." The requester submitted relevant information to support the Physical Medicine Procedure billed. **Recommend reimbursement according to the MAR for CPT code 97140 - \$1,023.90 (\$34.13 X 30 units)**.

CPT code 97012 on 3-16-04, 3-19-04, 3-26-04, 4-5-04 was denied as "NC" - The service is either not covered or the service is not recognized as a valid service or as "25" - this code is not consistent with other codes billed on the same day. Per Ingenix Encoder Pro this is a valid code for "Mechanical Traction." The requester submitted relevant information to support the procedure billed. **Recommend reimbursement of \$76.84 (\$19.21 X 4 DOS)**.

CPT code 97016 on 3-18-04, 3-19-04, 3-22-04, 3-26-04, was denied as "NC" - The service is either not covered or the service is not recognized as a valid service or as "25" - the code is not consistent with other codes billed on the same day. Per Ingenix Encoder Pro this is a valid code for a "Vasopneumatic device." The requester submitted relevant information to support the procedure billed. **Recommend reimbursement of \$73.60 (\$18.40 X 4 DOS)**.

CPT Code 97032 on 3-23-04 and 3-26-04 was denied as "JM" - The code and/or modifier billed is invalid or as "NC" - The service is either not covered or the service is not recognized as a valid service. Per Ingenix Encoder Pro this is a valid code for "Electrical stimulation-manual". Recommend reimbursement of **\$40.40 (\$20.20 X 2 DOS)**.

CPT Code 97032 on 3-31-04 was denied as "JF" - Documentation submitted does not substantiate the service billed. The requester submitted relevant information to support the Electrical Stimulation Procedure billed. **Recommend reimbursement of \$20.20.**

CPT Code 97032 on 4-5-04 and 4-7-04 was denied as "25" - The code is not consistent with other codes billed on the same date. Per Ingenix Encoder Pro CPT code 97140 is a mutually exclusive procedure of 97032. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The requestor used the modifier "59" to show that this is a distinct procedural service. **Recommend reimbursement of \$40.40 (\$20.20 X 2 DOS).**

CPT code 99214 on 5-6-04 was denied as "TG" - Documentation submitted does not support the service billed. Ingenix Encoder Pro states that CPT code 99214 is an office visit "which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity." The requestor submitted relevant information to support level of service billed. **Recommend reimbursement of \$106.36.**

CPT code 97799 on 5-17-04, 5-21-04 and 5-24-04, was denied as "YF" - Reduced or denied in accordance with the appropriate fee guideline ground rule and/or MAR. CPT code 97799 is a DOP code. Per Rule 133.307(g)(3)(D), the Requestor is also required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. **Recommend no reimbursement.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above for dates of service 2-3-04 through 5-24-04 **totaling \$2,119.34** as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or 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 and Order is hereby issued this 31<sup>st</sup> day of March 2005.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da

Enclosure: IRO decision

March 18, 2005

TEXAS WORKERS COMP. COMISSION  
AUSTIN, TX 78744-1609

CLAIMANT:

EMPLOYEE:

POLICY: M5-05-1597-01 /

CLIENT TRACKING NUMBER: M5-05-1597-01 /5278

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 received 3/2/05, 12 pages

EOB's from Texas Mutual Insurance Company, various dates, 37 pages

RECORDS RECEIVED FROM TEXAS MUTUAL INSURANCE COMPANY:

Letter of medical necessity from Bryan Weddle, DC dated 1/21/05, 4 pages

MRI of cervical spine report from Prestige Imaging, dated 8/4/04, 2 pages

MRI of Thoracic spine report from Prestige Imaging, dated 8/4/04, 2 pages

MRI of lumbar spine report from Preferred MRI-Scyene, dated 3/9/04, 2 pages

Follow up reports from Charles E. Willis II, MD, dated 3/19/04, 6/8/04, 7/12/04, 8/10/04, 8/31/04, 10/12/04, 6 pages

Procedure notes from Charles E. Willis II, MD dated 8/10/04 and 10/27/04, 2 pages

Exhibit A Letter of Clarification of #97140 undated, 1 page

Exhibit C letter of clarification of #97016 undated, 1 page

Exhibit B for #97110 undated, 1 page

Examination form, unknown physician, dated 1/27/04, 2 pages

SOAP notes, physician initials B.S., dated 1/27/04, 1/28/04, 1/29/04, 1/30/04, 2/3/04, 2/4/04, 2/5/04, 2/6/04, 2/9/04, 2/10/04, 2/11/04, 2/13/04, 2/16/04, 2/18/04, 2/20/04, 2/25/04, 2/27/04, 3/1/04, 3/3/04, 3/5/04, 3/10/04, 3/12/04, 3/15/04, 3/16/04, 3/17/04, 3/18/04, 3/19/04, 3/22/04, 3/23/04, 3/24/04, 3/25/04, 3/26/04, 3/29/04, 3/31/04, 4/2/04, 4/5/04,

4/8/04, 4/7/04, 4/12/04, 4/14/04, 4/16/04, 4/19/04, 4/21/04, 4/23/04, 4/26/04, 4/28/04, 4/30/04, 5/3/04, 5/5/04, 5/6/04, 5/10/04, 5/12/04, 5/14/04, 5/17/04, 5/19/04, 5/21/04, 5/24/04, 5/27/04, 6/1/04, 6/3/04, 6/7/04, 6/10/04, 6/17/04, 7/5/04, 121 pages  
Texas Workers Comp Work Status Report dated 3/12/04, 1 page

**Summary of Treatment/Case History:**

Patient underwent diagnostic imaging and extensive physical medicine treatments after being pinned by two motor vehicles in the course of his employment on .

**Questions for Review:**

1. Items In Dispute: Vasopneumatic device therapy (#97016), Manual Therapy (#97140-59), Therapeutic exercises (#97110), Office visits (#99215-25), Physical Medicine procedure (#97799), Electrical stimulation (#97032), Chiropractic manipulative treatment (#98940/#98941/#98943), Mechanical traction therapy (#97012). Denied with U codes for medical necessity.

**Explanation of Findings:**

1. Items In Dispute: Vasopneumatic device therapy (#97016), Manual Therapy (#97140-59), Therapeutic exercises (#97110), Office visits (#99215-25), Physical Medicine procedure (#97799), Electrical stimulation (#97032), Chiropractic manipulative treatment (#98940/#98941/#98943), Mechanical traction therapy (#97012). Denied with U codes for medical necessity.

Decision: All "U" disputed services from 02/09/04 through 02/23/04 are approved. All "U" disputed services after 02/23/04 are denied.

Rationale: The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*<sup>i</sup> Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Therefore, and supported by the re-examination performed on 02/11/04 that showed some degree of improvement, all "U" disputed services during the initial four weeks of treatment (from 01/26/04) through 02/23/04 are approved.

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains. After 02/23/04, there is no documentation of objective or functional improvement in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. In fact, the next re-examination was not even performed until 05/06/04. Therefore, the medical necessity for all "U" disputed services after 02/23/04 is not supported.

**Conclusion:**

All "U" disputed services during the initial four weeks of treatment (from 01/26/04) through 02/23/04 are medically appropriate.

**References Used in Support of Decision:**

Haldeman, S; Chapman-Smith, D; Petersen, D Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen Publishers, Inc.

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This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has written numerous publications and given several presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty-five years.

MRloA 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 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 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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