

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 2-22-05.

The IRO reviewed office visits, electrical stimulation, therapeutic exercises, mechanical traction, manual therapy techniques, and massage from 3-16-04 to 4-7-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO deemed that the office visits and therapeutic exercises from 3-16-04 to 4-7-04 were medically necessary **in the amount of \$845.42**. The IRO agreed with the previous adverse determination that electrical stimulation; mechanical traction, manual therapy, and massage from 3-16-04 to 4-7-04 were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

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

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 3-11-05, 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.

Codes 99212, G0283, 97110, 97012, 97140, E0720. and 97139 billed for date of service 3-9-04 were denied as N, 710 - additional documentation required to clarify service rendered and 730 - reduction/denial after reconsideration.

The respondent submitted their initial response on 3-16-05. The response included a corrected EOB dated 3-16-05 for date of service 3-9-04. The corrected EOB has a denial reason of "U, unnecessary medical. Per Rule 134.308 (j)(2), "the response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or defenses raised shall not be considered in the review." Therefore, this review for codes 99212, G0283, 97110, 97012, 97140, E0720. and 97139 billed for date of service 3-9-04 will be per Rules 133.307(g)(3)(B) and 134.202(b) and (c). The Progress Note date 3-9-04 supports the level of service for 99212 and services rendered for G0283, 97012, and 97140.

- Recommend the following reimbursements:
- 99212 - MAR is $\$35.33 \times 125\% = \44.16
- G0283 - MAR is $\$10.73 \times 125\% = \13.41
- 97012 - MAR is $\$14.33 \times 125\% = \17.91
- 97140 - MAR is $\$25.38 \times 125\% = \$31.72 \times 2 \text{ units} = \63.44

For code 97110 billed on 3-9-04 the following rationale applies: 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. The MRD declines to order payment for code 97110 because the Progress Notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

Code 97139 billed on 3-9-04 requires a descriptor. Per Medicare, "this code may be used if the clinician performs a therapeutic procedure to one or more body areas that is not listed under the current codes. A narrative descriptor should be noted on the claim." The bill did not include a descriptor and the Progress Notes did not clearly identify an unlisted therapeutic procedure. Therefore, no reimbursement recommended.

For DME code E0720 billed on 3-9-04, respondent paid \$85.00. Per the DMEPOS Fee Schedule, the reimbursement for this DME depends upon the modifier billed. The requestor did not bill with a modifier; therefore, additional reimbursement cannot be calculated.

ORDER

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 of \$845.42 (medical necessity fees) plus \$138.92 (general fees) outlined above 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 Order is applicable to dates of service 3-9-04 through 4-7-04 as outlined above in this dispute.

This Order is hereby issued this 12th day of April 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

Amended review date: March 23, 2005

Original review date: March 21, 2005

TEXAS WORKERS COMP. COMISSION

AUSTIN, TX 78744-1609

CLAIMANT: ___

EMPLOYEE: ___

POLICY: M5-05-1769-01

CLIENT TRACKING NUMBER: M5-05-1769-01-5278

AMENDED REVIEW: March 23, 2005

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:

8 page notification of IRO assignment from TWCC dated 3/14/05

8 pages of Explanation of Benefits, various dates

RECORDS RECEIVED FROM VALLEY SPINE MEDICAL CENTER:

6 page medical dispute resolution request/response

2 page request for reconsideration from Valley Spine Medical Center dated 5/4/04

2 page request for reconsideration from Valley Spine Medical Center dated 5/18/04

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15 pages of EOB's from Valley Spine Medical Center, various dates
2 page peer review from Consilium MD dated 4/4/04
2 page peer review from Consilium MD dated 4/18/04
2 page peer review from Consilium MD dated 5/2/04
3 page peer review from Consilium MD dated 5/19/04
2 page peer review from Consilium MD dated 6/7/04
14 pages of HCFA-1500 forms from Ruth Echavarria DC
1 page lumbar MRI study dated 2/19/04
1 page thoracic MRI study dated 2/19/04
10 pages of SOAP notes from Valley Spine Medical Center dated 3/9/04, 3/16/04, 3/17/04, 3/18/04,
3/30/04, 3/31/04, 4/1/04, 4/5/04, 4/6/04, 4/7/04
2 page Therapeutic Procedure Chart, undated
2 page report from Pete Garcia MD dated 2/5/04
1 page report from Dr. Garcia dated 2/16/04
1 page report from Dr. Garcia dated 2/24/04
1 page report from Dr. Garcia dated 3/15/04
1 page report from Dr. Garcia dated 4/22/04

RECORDS RECEIVED FROM ARKANSAS CLAIMS MANAGEMENT:

1 page letter from Arkansas Claims Management dated 3/17/05
2 page IRO Summary from Arkansas Claims Management dated 3/16/05
2 page peer review from Consilium MD dated 4/4/04
2 page peer review from Consilium MD dated 4/18/04
2 page peer review from Consilium MD dated 5/2/04
3 page peer review from Consilium MD dated 5/19/04
2 page peer review from Consilium MD dated 6/7/04
1 page notice of Disputed Issues dated 11/17/04
1 page notice of disputed issues dated 12/1/04
TWCC-73 Work Status Report from Dr. Garcia dated 2/5/04
TWCC-73 Work Status Report from Dr. Garcia dated 2/16/04
TWCC-73 Work Status Report from Dr. Garcia dated 2/25/04
1 page Employer First Report of Injury or Illness dated 2/2/04
2 page report from Pete Garcia, MD dated 2/5/04
1 page report from Pete Garcia, MD dated 2/16/04
1 page lumbar MRI study dated 2/19/04
1 page thoracic MRI study dated 2/19/04
1 page report from Dr. Garcia dated 2/24/04
1 page report from Dr. Garcia dated 3/15/04
2 page electrodiagnostic report dated 4/12/04
1 page report from Dr. Garcia dated 4/22/04
1 page report from Dr. Garcia dated 5/10/04
1 page report from Dr. Garcia dated 6/28/04
1 page report from Dr. Garcia dated 7/26/04

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1 page report from Dr. Garcia dated 8/24/04
TWCC-73 Work Status Report from Dr. Garcia dated 8/24/04
1 page report from Dr. Garcia dated 9/3/04
2 page report from NF Tsourmas MD dated 9/7/04
1 page report from Dr. Garcia dated 9/7/04
TWCC-73 Work Status Report from Dr. Garcia dated 9/7/04
1 page report from Dr. Garcia dated 9/21/04
TWCC-73 Work Status Report from Dr. Garcia dated 9/21/04
1 page report from Dr. Garcia dated 10/15/04
TWCC-73 Work Status Report from Dr. Garcia dated 10/15/04
TWCC-73 Work Status Report from Dr. Perez dated 10/20/04
9 page evaluation from Robert Fraser DC dated 11/18/04
TWCC-73 Work Status Report from Dr. Fraser dated 11/18/04
TWCC-73 Work Status Report from Dr. Conlon dated 11/29/04
1 page re-evaluation from William Conlon DC dated 12/13/04
TWCC-73 Work Status Report from Dr. Conlon dated 12/13/04
2 page report from Jorge Tijmes MD dated 12/14/04
TWCC-73 Work Status Report from Dr. Fraser dated 12/17/04
2 page report from Dennis Slavin MD dated 12/28/04
1 page report from Dennis Slavin MD dated 12/29/04
TWCC-73 Work Status Report from Dr. Conlon dated 12/30/04
TWCC-73 Work Status Report from Dr. Conlon dated 1/13/05
5 page functional capacity evaluation dated 1/19/05
5 page report from Gregory Goldsmith MD dated 2/4/05
TWCC-73 Work Status Report from Dr. Goldsmith dated 2/4/05
TWCC-73 Work Status Report from Dr. Conlon dated 2/11/05
TWCC-73 Work Status Report from Dr. Conlon dated 1/28/05
9 page FCE dated 2/22/05
30 pages of chiropractic progress notes for DOS 2/6/04 to 4/7/04
22 pages of progress notes for DOS 11/22/04 to 2/14/05

Summary of Treatment/Case History:

The patient, a 35-year-old male, injured his lower back and thoracic region on ____ when pulling a pallet at work. He went to Pete Garcia MD for evaluation and treatment on 2/5/04 and the examination revealed paraspinal tenderness, locally positive orthopedic tests, and lumbar muscle spasms. He was diagnosed with a thoracic and lumbar sprain/strain and he was referred for physical therapy with the chiropractor. The patient was treated on the following dates by the chiropractor:

February 2004: 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 25, 26
March 2004: 1, 3, 4, 9, 16, 17, 18, 30, 31
April 2004: 1, 5, 6, 7

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The medical records revealed that the patient was treated with office visits (#99212), therapeutic exercises (#97110), electrical stimulation (#G0283), manual therapy (#97140), mechanical traction (#97012), and massage (#97124) in varying combinations over the course of his care with the chiropractor.

A subsequent MRI study on 2/19/04 revealed the presence of bulging discs in the lower lumbar spine and the thoracic MRI study dated 2/19/04 was unremarkable. The patient was returned back to work at full duty without restrictions as of 2/25/04.

The 3/15/04 evaluation from Dr. Garcia revealed negative straight leg raising and no muscle spasms in the lumbar region. He continued on full duty status. A lower extremity EMG/NMCV evaluation was done on 4/12/04 and the 4/22/04 report from Dr. Garcia indicated the patient was still working full duty and he was doing better.

Questions for Review:

Please review DOS 3/9/04 through 4/7/04 and advise.

Items in dispute: CPT codes #99212 office/outpatient visit, est, #G0283 elec stim other than wound, #97110 therapeutic exercises, #97012 mechanical traction therapy, #97140 manual therapy and #97124 massage therapy, denied by carrier for medical necessity with U codes.

Explanation of Findings:

Please review DOS 3/9/04 through 4/7/04 and advise:

1. Items in dispute: CPT codes #99212 office visit/outpatient visit, established; #G0283 electrical stimulation, #97110 therapeutic exercises, #97012 mechanical traction therapy, and #97140 manual therapy and #99124 massage therapy, denied by carrier for medical necessity with U codes.

The use of the office visit (#99212) from 3/16/04 to 4/7/04 was medically necessary for the daily assessment of the patient. The use of therapeutic exercises (#97110) was medically necessary from 3/16/04 to 4/7/04. Haldeman et al indicate that it is beneficial to proceed to the rehabilitation phase of care as rapidly as possible to minimize dependence on passive forms of treatment/care and reaching the rehabilitation phase as rapidly as possible and minimizing dependence on passive treatment usually leads to the optimum result (Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993)

The use of manual therapy, massage therapy and electrical stimulation was not medically necessary from 3/16/04 to 4/7/04. The Philadelphia Panel found that therapeutic exercises were found to be beneficial for chronic, subacute, and post-surgery low back pain. Continuation of normal activities was the only intervention with beneficial effects for acute low back pain. For several interventions and indications (eg, thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy. (Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Low Back Pain. Phys Ther. 2001;81:1641-1674).

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The ACOEM Guidelines indicate that physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, TENS units, percutaneous electrical nerve stimulation units and biofeedback have no proven efficacy in the treatment of lower back pain symptoms (ACOEM Guidelines – Low Back Pain, 2003)

The Agency for Health Care Policy and Research: Clinical Practice Guideline Number 14, “Acute Low Back Problems In Adults” indicates that “the use of physical agents and modalities in the treatment of acute low back problems is of insufficiently proven benefit to justify its cost. They did note that some patients with acute low back problems appear to have temporary symptomatic relief with physical agents and modalities.

The use of mechanical traction from 3/16/04 to 4/7/04 was not medically necessary. The Royal College of General Practitioners indicates that there are now 24 randomized controlled trials of various forms of traction in neck and back pain but they are generally of poor quality. Traction does not appear to be effective for low back pain or radiculopathy. (Royal College of General Practitioners, Clinical Guidelines for the management of Acute Low Back Pain, Review Date: December 2001)

The European Guidelines for the Management of Acute Nonspecific Low Back Pain in Primary Care indicate that traction is not effective for the treatment of low back pain and the guideline recommends against the use of traction in the management of acute back pain (Van Tulder, M, et al, “European Guidelines for the Management of Acute Nonspecific Low Back Pain in Primary Care”, COST B13 Working Group for the Management of Acute Low Back Pain in Primary Care, 2004).

Conclusion/Decision to Certify:

The use of the office visit (#99212) from 3/16/04 to 4/7/04 was medically necessary for the daily assessment of the patient.

The use of therapeutic exercises (#97110) was medically necessary from 3/16/04 to 4/7/04.

Conclusion/Decision to Not Certify:

The use of manual therapy (#97140), massage therapy (#97124) and electrical stimulation (#G0283) was not medically necessary from 3/16/04 to 4/7/04.

The use of mechanical traction (#97012) from 3/16/04 to 4/7/04 was not medically necessary.

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

Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993

References Used in Support of Decision:

Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Low Back Pain. Phys Ther. 2001;81:1641-1674

ACOEM Guidelines – Low Back Pain, 2003

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Agency for Health Care Policy and Research: Clinical Practice Guideline Number 14, "Acute Low Back Problems In Adults"

Royal College of General Practitioners, Clinical Guidelines for the management of Acute Low Back Pain, Review Date: December 2001

Van Tulder, M, et al, "European Guidelines for the Management of Acute Nonspecific Low Back Pain in Primary Care", COST B13 Working Group for the Management of Acute Low Back Pain in Primary Care, 2004

This review was provided by a Doctor of Chiropractic who is also a member of the American Chiropractic Academy of Neurology. This reviewer also holds a certification in Acupuncture. This reviewer has fulfilled both academic and clinical appointments and currently serves as an assistant professor at a state college, is in private practice and is a director of chiropractic services. This reviewer has previously served as a director, dean, instructor, assistant professor, and teaching assistant at a state college and was responsible for course studies consisting of pediatric and geriatric diagnosis, palpation, adjusting, physical therapy, case management, and chiropractic principles. This reviewer is responsible for multiple postgraduate seminars on various topics relating to chiropractics and has authored numerous publications. This reviewer has participated in numerous related professional activities including work groups, committees, consulting, national healthcare advisory committees, seminars, National Chiropractic Coalition, media appearances, and industrial consulting. This reviewer has been in practice since 1986.

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.

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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

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