

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 2-28-05.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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 IRO reviewed motor nerve conduction tests, somatosensory testing, manual therapy, neuromuscular reeducation, ice packs, mechanical traction therapy, electrical stimulation, chiropractic manipulation, massage and office visits that were denied for medical necessity from 3-5-04 through 7-2-04.

The manual therapy, neuromuscular reeducation, ice packs, mechanical traction therapy, electrical stimulation, chiropractic manipulation, massage and office visits from 3-5-04 through 4-2-04 **were found** to be medically necessary. The motor nerve conduction tests and somatosensory testing on 3-30-04, manual therapy, neuromuscular reeducation, ice packs, mechanical traction therapy, electrical stimulation, chiropractic manipulation, massage and office visits from 4-5-04 through 7-2-04 **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 the medical necessity issues is \$128.62.**

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 3-18-05 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.

Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge.

CPT code G0283 on 3-5-04 was denied as “R-95 – Procedure Billing Restricted-See Medicare LCD”. Per Ingenix Encoder Pro, “Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care.” Per Trailblazer “Electrical stimulation must be utilized with appropriate therapeutic procedures (e.g., 97110) to effect continued improvement.” This service was not utilized with a therapeutic procedure. **Recommend no reimbursement.**

CPT code 99070 for Baldrian, Inflammax and Biofreeze on 3-5-04 and 3-24-04 was denied as “R38 – Included in another billed procedure.” Per Rule 133.304(c) and 134.202(a)(4) carrier didn’t specify which service this was included with. **Recommend reimbursement per Rule 134.202(c)(1) of \$39.00.**

CPT code 99070 for Cervical Pillow on 3-16-04 was denied as “R38 – Included in another billed procedure.” Per Rule 133.304(c) and 134.202(a)(4) carrier didn’t specify which service this was included with. **Recommend reimbursement per Rule 134.202(c)(1) of \$30.00.**

CPT code 97110 on 3-26-05 and 4-7-04 was denied as “130 - Services unsubstantiated by documentation.” 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 96110 on 3-16-04: The requestor did submit a correct medical bill per Rule 133.307 (e)(2)(A). Neither the carrier nor the requestor provided EOB’s. The requestor submitted convincing evidence of carrier receipt of provider’s request for EOB’s in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s Per Rule 133.307(e)(3)(B). **Recommend reimbursement per Medicare Fee Guidelines of \$16.60.**

CPT code 99212-25 on 3-8-04 was denied by the carrier as “130 - Services unsubstantiated by documentation.” Requestor did submit relevant documentation to support service rendered per Rule 133.307(g)(3)(B). **Recommend reimbursement of \$32.00.**

CPT code G0283 on 3-9-04, 3-11-04, 3-16-04, 3-17-04, 3-18-04, 3-22-04, 3-23-04, 3-26-04, 4-1-04, 4-7-04, 4-9-04, 4-12-04, 4-14-04 and 4-16-04 was denied by the carrier as “130- Services unsubstantiated by documentation.” Requestor did submit relevant documentation to support service rendered per Rule 133.307(g)(3)(B). **Recommend reimbursement of \$187.74 (\$13.41 X 14 DOS).**

CPT code 97140-59 on 3-9-04, 3-24-04, 3-26-04, 4-9-04 and 4-12-04 was denied by the carrier as “130 - Services unsubstantiated by documentation.” Requestor did submit relevant documentation to support service rendered per Rule 133.307(g)(3)(B). **Recommend reimbursement of \$154.50 (\$30.90 X 5 DOS).**

CPT code 97012 on 3-11-04, 3-16-04, 3-17-04, 3-18-04, 3-22-04, 3-23-04, 3-26-04, 4-1-04, 4-7-04, 4-9-04, 4-12-04, 4-14-04 and 4-16-04 was denied by the carrier as “130- Services unsubstantiated by documentation.” Requestor did submit relevant documentation to support service rendered per Rule 133.307(g)(3)(B). **Recommend reimbursement of \$232.83 (\$17.91 X 13 DOS).**

CPT code 97124-59 on 3-16-04, 3-17-04, 3-18-04, 3-22-04, 3-23-04, 3-24-04, 3-26-04, 4-1-04, 4-12-04, 4-14-04 and 4-16-04 was denied by the carrier as “130- Services unsubstantiated by documentation.” Requestor did submit relevant documentation to support service rendered per Rule 133.307(g)(3)(B). **Recommend reimbursement of \$282.70 (\$25.70 X 11 DOS).**

CPT code 97124-59 on 4-7-04 was denied by the carrier as “R79 - Standards of Medical Surgical Practice”. 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).” The carrier’s EOB denial is unclear. Therefore, these services will be reviewed in accordance with the Medicare Fee Schedule. **Reimbursement is recommended in the amount of \$25.70.**

CPT code 97112 on 3-23-04 and 3-24-04 was denied by the carrier as “R79 - Standards of Medical Surgical Practice”. 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).” The carrier’s EOB denial is unclear. Therefore, these services will be reviewed in accordance with the Medicare Fee Schedule. **Reimbursement is recommended in the amount of \$66.82 (\$33.41 X 2 DOS).**

CPT code 97112 on 3-26-04, 4-7-04, 4-14-04 was denied by the carrier as “130 - Services unsubstantiated by documentation.” Requestor did submit relevant documentation to support service rendered per Rule 133.307(g)(3)(B). **Recommend reimbursement of \$100.23 (\$33.41 X 3 DOS).**

CPT code 97112 on 4-5-04 was denied by the carrier as “global to 98940”. Per Ingenix Encoder Pro, “CPT code 97112 is considered by Medicare to be a component procedure of CPT code 98940. **Recommend no reimbursement.**

CPT code 97124-59 on 4-5-04 was denied by the carrier as “global to 98940”. Per Ingenix Encoder Pro, “CPT code 97112 is considered by Medicare to be a component procedure of CPT code 98940. A modifier is allowed in order to differentiate between the services provided.” **Recommend reimbursement of \$25.70.**

CPT code 98940 on 4-9-04 and 4-12-04 was denied by the carrier as “130 - Services unsubstantiated by documentation.” Requestor did submit relevant documentation to support service rendered per Rule 133.307(g)(3)(B). **Recommend reimbursement of \$60.25 (\$30.14 X 2 DOS).**

CPT code 99080-73 on 4-26-04, 5-24-04, and 6-25-04 was denied by the carrier with for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. A referral will be made to Compliance and Practices for this violation of the Rule. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. **Recommend reimbursement of \$45.00.**

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 totaling \$1,427.69 for 3-5-04 through 6-25-04 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 Findings and Decision and Order is hereby issued this 26th day of May, 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

Medical Review Institute of America, Inc.
America's External Review Network

MRIOA

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April 4, 2005

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT:
POLICY: M5-05-1793-01
CLIENT TRACKING NUMBER: M5-05-1793-01 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, 3/18/05
- Texas Worker's Compensation Commission notice of receipt of request for Medical Dispute Resolution, 3/21/05
- Medical Dispute Resolution Request/Response form
- Table of disputed services
- Explanation of Review forms, x40 pages

Records from Byrd Chiropractic

- Case Summary, 3/28/05
- Bills, 3/5/04 through 7/2/04
- Clinic notes, 3/9/04 through 7/2/04
- Re-examinations, 3/5/04, 4/21/04, 5/24/04
- Lower body stretching forms, 3/23/04 through 5/12/04
- Exercise logs, 3/23/04 through 5/12/04
- Release form, 3/29/04
- Radiology order, and radiology report, 6/4/04
- Nerve testing charge list, 3/30/04
- Quadruple visual analogue scale, 5/6/04
- Referrals, 3/9/04, 3/11/04
- Initial functional capacity evaluation, 5/3/04
- Diagnostic interview, 5/10/04
- Neurology testing interpretation, 3/30/04
- Pain drawing, 3/30/04
- Nerve conduction studies, 3/30/04
- Radiology report, 3/5/04
- MRI report, 3/12/04

Summary of Treatment/Case History:

The patient underwent diagnostic imaging, NCV and physical medicine treatments after injuring his lumbar spine and neck while digging a 10-foot hole 3-feet in depth on 03/02/04.

Questions for Review:

1. Were the listed items in dispute on 03/5/04 through 07/02/04 medically necessary to treat this patient's injury?

Items in dispute: CPT codes #95900, #95903, and #95904 (motor nerve conduction test), #95925 (somatosensory testing), #97140-59 (manual therapy, distinct procedural service), #97112 (neuromuscular reeducation), #97012 (mechanical traction therapy), #G0283 (electrical stimulation, other than wound), #98940 (chiropractic manipulation), #97124-59 (massage therapy, distinct procedural service), #99214-25 (office/outpatient visit, established patient with significant separate E/M performed by the same physician on the same date of service denied by the carrier for Medical Necessity with "V" codes.

Explanation of Findings:

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* (ref. 1) 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.” The ACOEM Guidelines (ref. 2) state that if manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated.

In this case, the 4-week period ended on 04/02/04, but no re-examination was performed at that time. Therefore, since there was no objective basis for continuing treatment, it was medically unnecessary. Moreover, the patient’s lack of response to treatment is documented by his subjective “50%” (or lower) improvement ratings on each and every visit from 03/15/04, all the way through 04/23/04.

While a physical re-examination was indicated after 4 weeks of treatment, no documentation was furnished to support the medical necessity of the motor nerve conduction tests and the somatosensory tests performed on 03/30/04.

It is also important to note that there was no material improvement in the patient’s condition between the 04/21/04 and 05/24/04 re-examinations; and the designated doctor (who carries presumptive weight) at some time prior to 06/11/04 determined the claimant to be MMI with 0% whole body impairment.

Conclusion/Decision to Not Certify:

None of the services in question are certified as medically necessary.

References Used in Support of Decision:

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

ACOEM Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition, p. 299.

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.

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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