

M5-05-1954-01

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 03-14-05.

Per Rule 133.308(e)(1) dates of service 01-05-04 through 03-04-04 were not timely filed and will therefore not be a part of the review.

The IRO reviewed office visits, chiropractic manipulation, neurological re-education, manual therapy technique, electrical stimulation rendered from 03-17-04 through 07-06-04 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 04-12-05, 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.

Review of CPT codes 99213-MP, 98943, 97112, 97140-59 on dates of service 03-31-04 and 05-26-04 as well as code G0283 on date of service 06-04-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(A) the requestor did not submit for review "a copy of the medical bill(s) as originally submitted to the carrier for reconsideration". No reimbursement is recommended.

Review of CPT code 99213 dates of service 06-02-04, 06-04-04, 06-07-04, 06-08-04, 06-09-04, 06-14-04, 06-16-04, 06-21-04 and 06-22-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement per Rule 134.202(c)(1) is \$61.98 (\$49.58 X 125%). The requestor billed \$48.00 for each date of service in dispute. Reimbursement is recommended in the amount of **\$432.00 (\$48.00 X 9 DOS)**.

Review of CPT code 98943 dates of service 06-02-04, 06-04-04, 06-07-04, 06-08-04, 06-09-04, 06-14-04, 06-16-04, 06-21-04 and 06-22-04 revealed that neither party submitted copies of EOBs. Per Ingenix Encoder.Pro code 98943 is noncovered by Medicare. The Section Notes for codes 98940-98943 in Ingenix state: "Consult the appropriate Evaluation and management CPT code and append modifier 25 (or 09925) in addition to the code when separately identifiable Evaluation and Management services, above and beyond any pre or post service work associated CMT, are provided". No reimbursement recommended.

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Review of CPT code 97112 (36 units) dates of service 06-02-04, 06-04-04, 06-07-04, 06-08-04, 06-09-04, 06-14-04, 06-16-04, 06-21-04 and 06-22-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$1,234.80** (**\$27.44 X 125% = \$34.30 X 36 units**).

Review of CPT code 97140-59 dates of service 06-02-04, 06-04-04, 06-07-04, 06-08-04, 06-09-04, 06-14-04, 06-16-04, 06-21-04 and 06-22-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$285.57** (**\$25.38 X 125% = \$31.73 X 9 DOS**).

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 06-02-04 through 06-22-04 totaling \$1,952.37 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 23rd day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

May 17, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-1954-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 40 year-old male injured his back and neck on ____ in a work related event. He has been treated with various forms of therapy.

Requested Service(s)

Office visit, chiropractic manipulation, neurological re-education, manual therapy technique, electrical stimulation for dates of service 03/17/04 through 07/06/04

Decision

It is determined that there is no medical necessity for the office visit, chiropractic manipulation, neurological re-education, manual therapy technique, and electrical stimulation for dates of service 03/17/04 through 07/06/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient was seen 56 times from 01/05/04 through 07/06/04 with a no change in treatment or improvement. He stated his pain rated 8 out of 10 at every visit. 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.

The Guidelines of *Chiropractic Quality Assurance and Practice Parameters*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." In this case, the 4-week maximum for non-responsive treatment ended prior to the dates of service in question. Therefore, the office visit, chiropractic manipulation, neurological re-education, manual therapy technique, and electrical stimulation for dates of service 03/17/04 through 07/06/04 was not medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1954-01

Information Submitted by Requestor:

- Progress Notes
- Diagnostic Tests
- Letters of Medical Necessity
- Claims/Miscellaneous

Information Submitted by Respondent:

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¹ Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractor Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.