

MDR Tracking Number: M5-05-2651-01

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 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 6-30-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on 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 office visits, unlisted modality (aqua therapy), hot-cold packs, electrical stimulation, radiologic examination, new patient evaluation, medical conference, office consultation and therapeutic activities that were denied by the insurance carrier for medical necessity from 7-14-03 through 4-2-04.

The office visits, unlisted modality (aqua therapy), hot-cold packs, electrical stimulation, radiologic examination, new patient evaluation, medical conference, office consultation and therapeutic activities that were denied by the insurance carrier for medical necessity from 7-14-03 through 4-2-04 were found to be medically necessary. (CPT code 99361 is always a bundled code Reimbursement is not recommended.) The amount due the requestor for the medical necessity issues is \$4,068.06.

The carrier denied some items for both “R - Extent of Injury” and “V-Unnecessary treatment with peer review.” However, a Benefit Contested Case Hearing on 5-13-04 ruled that the 8-5-01 compensable injury includes an injury to the neck. Since the “R” denial code was thus adjudicated, these services were reviewed by the IRO. All services that had been denied for medical necessity were found by the IRO to be medically necessary.

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 9-13-05 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.

Regarding CPT code G0283 on 8-1-03, 8-4-03, 8-6-03, 8-8-03, 8-11-03, 8-13-03, 8-15-03, 8-18-03, 8-20-03, 8-22-03, 8-26-03, 8-28-03, 9-2-03, 9-4-03, 9-9-03, 9-11-03, 9-16-03, 9-18-03, 9-23-03, 9-25-03, 10-2-03, 10-9-03, 11-21-03, 11-25-03, 12-5-03, 12-11-03, 12-19-03, 12-24-03, 1-2-04, 1-7-04, 1-22-04, 1-27-04, 2-5-04 and 2-10-04, 2-24-04: 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 of \$566.51 (16.63 X 28 DOS+ \$14.41 X 7 DOS).**

Regarding CPT code 97039 on 9-23-03, 1-2-04, 1-7-04, 1-22-04, 1-27-04, 2-5-04 and 2-10-04: 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 of \$89.16 (\$15.10 + \$14.86 X 6 DOS).**

Regarding CPT code 99213 on 9-23-03, 11-13-03, 12-2-03, 1-7-04, 1-27-04, 1-29-04, 2-4-04, 2-5-04, 2-10-04, 2-24-04, 3-4-04, 3-8-04: 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 of \$746.54 (\$66.19 X 2 DOS + \$68.24 X 9 DOS).**

Regarding CPT code 99215 on 11-21-03: 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 of \$150.83.**

CPT code 99358 on 12-2-03: 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). (This CPT code is always a bundled code. **Recommend no reimbursement.**

CPT code 99204-75 on 1-7-04: 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 of \$170.13.**

Regarding CPT code 99080 on 1-22-04: 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 of \$256.45.**

CPT code 97535 on 2-4-04 (2 units): 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 of \$77.10 (38.55 X 2 DOS).**

CPT code 99499-52 on 4-14-04: 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 of \$40.00.**

This Finding and Decision is hereby issued this 16th day of June, 2005.

Medical Dispute Resolution Officer
Medical Review Division

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 \$6,164.78 from 7-14-03 through 4-14-04 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 Order is hereby issued this 16th day of June, 2005.

Manager, Medical Necessity Team
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

MEDICAL REVIEW OF TEXAS
[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISION II - 6/13/05

TWCC Case Number:	
MDR Tracking Number:	M5-05-2651-01
Name of Patient:	
Name of URA/Payer:	Parker Chiropractic
Name of Provider: (ER, Hospital, or Other Facility)	Parker Chiropractic
Name of Physician: (Treating or Requesting)	John Parker, DC

September 9, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services

is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Available documentation received and included for review consist of records from Drs. Anagnostis (MD) Gandhi (MD) Blair (MD) Nguyen and Parker (DC) including treatment / office visits, CT evaluations, MRI scans, functional assessment and MMI / impairment reports.

Ms. ____, a 42-year-old female, was injured on the job while working for _____. She was walking quickly down a hall reading some papers when she struck her head on a ledge projecting from the wall. She was knocked backwards and fell down. She initially sought treatment from Dr. Anagnostis who diagnosed her with postconcussion syndrome. CT scans ruled out intracranial hemorrhage. Neurologic consult with Dr. Ghandi determined closed head injury with muscle contraction type headaches secondary to whiplash. The patient was managed with medication without any physical treatment. In May of 2002 MRI's identified diffuse pituitary enlargement. Drs. Blair and Nguyen evaluated her and determined headaches of myofascial origin and recommended general cervical exercises. In July of 2003, she was seen by Dr. Parker, a chiropractor. At this time she was complaining of bilateral head pain, neck, upper and lower back pain with weakness in the left shoulder and arm. Dr. Parker Instituted a conservative treatment program régime consisting of manipulation and adjunctive physiotherapeutic modalities. Her initial pain scale was 8/10. The documentation supplied showed the patient responded to care with a progressive reduction in her pain scale, with occasional flare-ups. A stationary platform was achieved in January 2004 with a pain level of 3/10. The patient was evaluated by Dr. David Spinks, (DO) on 2/17/04 and determined to be at MMI with a 5% whole person impairment. Dr. Parker agreed with this assessment. The patient was seen on subsequent visits in March for exacerbations of her pain.

REQUESTED SERVICE(S)

Medical necessity of office visits (99213), office visits with manipulation (99213MP), unlisted modality (aqua therapy 97039), hot/cold packs 97010, electrical stimulation (97014/G0283), radiologic examination (72040), new patient evaluation (99203), medical

conference (99361), office consultation (99244), therapeutic activities, (97530). Date range: 7/14/03-4/2/04.

DECISION

Approved. There is establishment of medical necessity for all disputed services in the date range 7/14/03-4/2/04.

RATIONALE/BASIS FOR DECISION

The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

The patient was placed on a fairly comprehensive treatment régime with documented benefit. By the time the patient consulted with Dr. Parker, a substantial period of time had elapsed since the date of injury. The degree of chronicity serves as a fairly significant complicating factor regarding time frame of care. The patient had not had any physical medicine intervention prior to meeting with Dr. Parker. The patient had undergone significant management prior to presentation which required ongoing case management services.

Treatment affected a favorable response and was discontinued once a stable baseline of improvement had been achieved. Services rendered satisfy the above definition of medical necessity.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140