Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor=s Name and Address: Houston Pain and Recovery Clinic % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	MDR Tracking No.: M5-06-0177-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: TX Mutual Insurance Company, Box 54	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "The above indicates that the treatment provided for the claimant was medically reasonable and necessary. We are requesting reimbursement for all disputed dates of services."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response and Explanations of Benefits. Position summary was a request for a "review and hearing."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
10-25-04 – 11-5-04	CPT code 97032, 97140	☒ Yes ☐ No	$309.83
11-9-04 – 3-16-05	CPT code 97032, 97140	☐ Yes ☒ No	0
12-28-04 – 3-16-05	CPT code 97110	☒ Yes ☐ No	$1,078.16
12-28-04 – 3-16-05	CPT code 97112	☐ Yes ☒ No	0
10-25-04 – 3-16-05	HCPCS Code E1399	☐ Yes ☒ No	0
1-31-05, 2-16-05, 3-16-05	CPT code 99213	☒ Yes ☐ No	$201.60
11-2-04, 11-9-04, 11-16-04, 11-29-04, 12-05-04, 12-8-04, 12-21-04, 12-28-04	CPT code 99212	☐ Yes ☒ No	0
11-2-04, 11-29-04, 1-21-05, 1-24-05	CPT code 99212	☒ Yes ☐ No	$145.47
12-30-04	CPT code 99214	☐ Yes ☒ No	0

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor did not prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is $1,735.06.

Based on review of the disputed issues within the request, the 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 Medical Dispute Resolution.

On 10-11-05 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.

On 12-6-05 the requestor sent a revised table withdrawing services that had been reimbursed by the carrier.

CPT code 97001 on 10-25-04 was denied by the carrier as "CAC-16 – Claim lacks information which is needed." The requestor did provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of $95.15.

HCPCS code E1399 on 10-25-04, 11-16-04, 11-22-04, 12-5-04 and 12-21-04 was either shown as having been reimbursed (The provider says that it was not) or it was denied by the carrier as "217- The value of this procedure is included in the value of another procedure performed on this date." Per the 2002 MFG, "This code should be used only if a more specific code is unavailable." The requestor did not provide documentation to enable the Division to determine to what this code refers. Therefore, it is impossible to determine if it was bundled with another code. No reimbursement recommended.

CPT code 97110 on 10-27-04 was denied as "420-supplemental payment": The EOB's show that this service has been reimbursed. The provider says that it has not. 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 Worker's Compensation 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. Additional reimbursement not recommended.

CPT code 97110 on 11-23-04 was denied as "790-this charge was reduced in accordance to the TX medical fee guideline": 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 Worker's Compensation Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order additional 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.

CPT code 97112 on 11-23-05 was denied as "790-This charge was reduced in accordance to the TX medical Fee Guideline." The EOB shows that the carrier has reimbursed $34.30. The requestor states that it has not. Recommend reimbursement of $36.75 (MAR).

CPT code 97112 on 12-1-04 was denied as "143-Portion of payment deferred." The EOB shows that the carrier has reimbursed $37.04. The requestor states that it has not. Recommend reimbursement of $36.75.

CPT code 97110 on 12-13-04 (2 units) was denied as "143-Portion of payment deferred." The EOB shows that the carrier has reimbursed $74.08. The requestor states that it has not. Recommend reimbursement of $74.08.

CPT code 99080-73 on 11-19-04, 12-16-04, 1-31-05, 2-16-05 and 3-16-05 was denied by the carrier as "248-DWC 73 not properly submitted." In accordance with Rule 129.5, the requestor submitted copies of the DWC 73 report. Recommend reimbursement of $75.00 ($15.00 X 5 DOS).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5, 133.308 and 134.202(c)(1).

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of $2,032.75. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

	Donna Auby	12-28-05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

November 28, 2005

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M5-06-017701
CLIENT TRACKING NUMBER: M5-06-0177-01 5278

Amended review: 12/20/05.

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). TheTexas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIoA for independent review in accordance with DWC 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 DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

Records Received:

Records Received from the State:

- Notification of IRO Assignment, 10/11/05 – 2 pages
- Medical Dispute Resolution Request/Response, undated – 2 pages
- Table of Disputed Services, undated – 14 pages
- EOBs, 12/17/04-5/11/05 – 19 pages

Records Received from Texas Mutual:

- Medical Dispute Resolution Request/Response, undated – 1 page
- Letter from Texas Mutual to Texas Department of Insurance, 10/18/05 – 3 pages
- Pain and Recovery Clinic of Houston – SW Daily Progress Notes, 10/25/04-3/16/05 – 39 pages
- Optimum Medical Testing Electrodiagnostic Evaluation, undated – 2 pages

Records Received from Pain and Recovery c/o Bose Consulting:

- Bose Consulting List of Exhibits – 2 pages
- Bose Consulting LLC Position Statement, undated – 3 pages
- Fort Bend Imaging MRI, 11/11/04 – 1 Page
- Optimum Medical Testing EMG – undated – 4 pages
- Orthopedic Consult from Dr. Donovan, 12/9/04 – 2 pages
- Board Certified Orthopaedic Surgeon from Dr. LeCompte, 3/31/05 – 6 pages
- U.S. Anesthetics Services, PA Pain Management Initial Evaluation from Dr. McKay, 12/7/04 – 3 pages
- U.S. Anesthetics Services, PA Comprehensive Pain Follow Up from Dr. McKay, 4/19/05 – 3 pages
- U.S. Anesthetics Services, PA Comprehensive Pain Follow Up from Dr. McKay, 4/19/05 – 3 pages
- U.S. Anesthetics Services, PA Comprehensive Pain Follow Up from Dr. McKay, 6/14/05 – 2 pages
- Pain and Recovery Clinics of Houston – SW Impairment Rating and MMI Dispute from Dr. Hicks, 5/2/05 – 1 page
- Pain and Recovery Clinics of Houston – SW Subsequent Medical Report from Dr. Hicks, 4/18/05 – 2 pages
- Pain and Recovery Clinics of Houston – SW Impairment Rating and MMI Dispute from Dr. Hicks, 5/2/05 – 3 page
- Pain and Recovery Clinics of Houston – SW Impairment Rating and MMI Dispute from Dr. Hicks, 6/2/05 – 3 page
- Pain and Recovery Clinics of Houston – SW Subsequent Medical Report from Dr. Hicks, 6/1/05 – 3 pages
- Pain and Recovery Clinics of Houston – SW Subsequent Medical Report from Dr. Hicks, 12/16/04 – 3 pages
- Pain and Recovery Clinics of Houston – SW Subsequent Medical Report from Dr. Hicks, 1/31/05 – 3 pages
- Pain and Recovery Clinics of Houston – SW Subsequent Medical Report from Dr. Hicks, 2/16/05 – 2 pages
- Pain and Recovery Clinics of Houston – SW Subsequent Medical Report from Dr. Hicks, 6/30/05 – 2 pages

- Pain and Recovery Clinics of Houston – SW Subsequent Medical Report from Dr. Hicks, 7/21/05 – 2 pages
- Pain and Recovery Clinics of Houston – SW Initial Medical Report from Dr. Hicks, 10/19/04 – 2 pages
- Pain and Recovery Clinics of Houston – SW Subsequent Medical Report from Dr. Hicks, 3/16/05 – 2 pages
- Pain and Recovery Clinics of Houston – SW Subsequent Medical Report from Dr. Hicks, 2/16/05 – 2 pages
- Pain and Recovery Clinics of Houston – SW Subsequent Medical Report from Dr. Hicks, 1/31/05 – 3 pages
- Pain and Recovery Clinics of Houston – SW Causation Letter from Dr. Hicks, 2/17/05 – 1 page
- Pain and Recovery Clinics of Houston – SW Causation Letter from Dr. Hicks, 2/22/05 – 3 pages
- Subsequent Medical Report from Dr. Long, 11/22/04 – 1 page
- Pain and Recovery Clinics of Houston – SW Initial Medical Report from Dr. Long, 10/22/04 – 2 pages
- Pain and Recovery Clinics of Houston – SW Initial Therapy Evaluation from Lee Nickel, 10/25/04 – 2 pages
- Optimum Medical Testing Functional Capacity Evaluations, 5/11/05 – 18 pages
- Optimum Medical Testing Impairment Evaluation, 7/12/05 – 7 pages
- Optimum Medical Testing Functional Capacity Evaluations, 7/6/05 – 16 pages
- Texas Workers' Compensation Work Status Report, 3/16/05 – 1 page
- Texas Workers' Compensation Work Status Report, 2/16/05 – 1 page
- Texas Workers' Compensation Work Status Report, 11/19/04 – 1 page
- Texas Workers' Compensation Work Status Report, 12/16/04 – 1 page
- Texas Workers' Compensation Work Status Report, 1/31/05 – 1 page
- Pain and Recovery Clinics of Houston – SW Daily Progress Note, 10/19/04-8/1/05 – 68 pages

Summary of Treatment/Case History:
The patient, a 25-year-old male, developed severe lower back pain while lifting a box at work weighing 50 lbs on ___. He went to Pain and Recovery Clinics of Houston on 10/25/04 complaining of lower back pain worse on the right with what was described as lower extremity radiculopathy. The examination revealed reduced lumbar ranges of motion and hip flexor weakness bilaterally. Right straight leg raising was 40 degrees with lower back pain and leg pain. Left straight leg raising was to 60 degrees with lower back pain. The neurological examination was unremarkable and the patient was diagnosed with lumbar intervertebral disc syndrome and myofascial pain syndrome. A course of treatment consisting of manipulation, joint mobilization, electrical stimulation, manual therapy, neuromuscular reeducation, office visits, and therapeutic exercises was initiated and the patient was treated on the following dates by the chiropractor:

10/19/04, 10/22/04, 10/25/04, 10/27/04, 10/29/04, 11/2/04, 11/4/04, 11/5/04, 11/9/04, 11/10/04, 11/16/04, 11/17/04, 11/19/04, 11/22/04, 11/23/04, 11/24/04, 11/29/04, 12/1/04, 12/2/04, 12/5/04, 12/8/04, 12/10/04, 12/13/04, 12/16/04, 12/17/04, 12/21/04, 12/23/04, 12/28/04, 12/30/04, 1/4/05, 1/7/05, 1/10/05, 1/12/05, 1/14/05, 1/17/05, 1/20/05, 1/21/05, 1/24/05, 1/27/05, 1/28/05, 1/31/05, 2/16/05, 3/16/05, 4/18/05, 4/22/05, 4/25/05, 4/27/05, 4/29/05, 5/2/05, 5/6/05, 5/18/05, 5/24/05, 5/25/05, 5/31/05, 6/7/05, 6/8/05, 6/14/05, 6/21/05, 6/23/05, 7/1/05, 7/5/05, 7/22/05, and 8/1/05.

A lumbar MRI study was ordered on 11/11/04 that revealed no evidence of disc protrusion from T12-L1 to L3-4 and a 1.5 mm generalized bulge at L4-5.

The claimant was referred to Walter Long MD for medication treatments on 11/22/04 and he was referred to Andrew McKay MD for a pain management consultation on 12/7/04. He complained of lower back pain rated at 9/10 and he complained of buttock pain, posterior thigh pain, and pain radiating to the lower legs and heel on the right. The examination revealed lumbar tenderness, negative straight leg raising, and a normal neurological examination. He was diagnosed with bilateral lumbar facet arthropathy and failed conservative treatment. Lumbar facet injections were recommended at the L4-5 and L5-S1 levels.

The claimant was referred to William Donovan MD for an orthopedic consultation on 12/9/04 and he complained of lower back pain with bilateral radiating leg pain that was worse on the right side. The examination revealed reduced lumbar flexion, a reduced right Achilles reflex and hypersensitivity in the right S1 distribution. He was diagnosed with a right L5-S1 disc herniation. Rehabilitation, pain management treatments, epidural steroid injections, and a right S1 nerve block was recommended.

The claimant was re-examined by the chiropractor on 12/16/04 and the examination revealed reduced left patellar and Achilles reflexes and global right lower extremity weakness. The patient was referred for more physical therapy and to Dr. McKay for pain management.

The claimant underwent a lower extremity EMG/NCV evaluation on 1/6/05 that revealed evidence of possible lumbar radiculopathy of the right and left L5 nerve roots, but there was no EMG evidence to confirm the diagnosis.

The claimant was re-examined by the chiropractor on 1/31/05 and lumbar orthopedic tests were locally positive and deep tendon reflexes were normal. Weakness was noted in the right extensor hallucis longus muscle. Treatments continued unchanged from previous physical medicine treatments.

The claimant was subsequently re-examined by Dr. Hicks (chiropractor) on 2/16/05 and no significant changes were noted in the examination. The claimant continued to complain of lower back pain and pain radiating to the right foot. Treatments were placed on hold pending a BRC hearing.

The claimant was re-examined on 3/16/05 by the chiropractor and he complained of lower back pain rated at 6/10 and right leg pain. The examination revealed locally positive lumbar orthopedic tests and straight leg raising was positive at 55 degrees on the right and 65 degrees on the left. The remainder of the evaluation was unchanged from previous evaluations.

The claimant underwent an IME with Michael LeCompte DO, an orthopedic surgeon, on 3/22/05. The claimant indicated treatments were not helping and he complained of constant lower back pain and occasional right leg pain. The neurological examination was unremarkable and the claimant was diagnosed with right sided facet disease in the lumbar region and a lumbar sprain/strain. Facet injections were recommended for the L4-5 and L5-S1 level.

The claimant was re-examined by the chiropractor on 4/18/05 and he continued to complain of lower back pain and right-sided leg pain. The examination was essentially unchanged from the previous evaluation and the claimant was referred for pain management injections to the lumbar region. He was also referred for more physical therapy treatments. Chiropractic and physical therapy treatments continued through 8/1/05.

Questions for Review:

1. Dates of service in question are 10/25/04 – 03/16/05. Items in dispute: #97032 (electrical stimulation), #97140 (manual therapy), #99212, #99213, #99214 (OV), #E1399 DME, #97110 (therapeutic exercises), and #97112 (neuromuscular reeducation), which were denied for medical necessity.

Explanation of Findings:

The office visits (#99212) billed on 11/2/04, 11/9/04, 11/16/04, 11/29/04, 12/5/04, 12/8/04, 12/21/04, and 12/28/04 were not medically necessary. A review of the progress notes for dates of service before and after the above-noted dates of service revealed no changes in the notes supportive of the additional billing for #99212.

The office visit (#99214) billed on 12/30/04 was not medically necessary, as there was no documentation in the records submitted for review supporting any diagnostic/office visit services being rendered on that date of service.

The #99213 office visits billed on 1/31/05, 2/16/05 and 3/16/05 were medically necessary and supported by documentation reviewed.

The use of electrical stimulation (#97032) and manual therapy (#97140) was medically necessary from 10/25/04 to 11/5/04 and was not medically necessary from 11/09/04 through 3/16/05. The medical records revealed that these services were billed from the inception of care in 10/04 and the records reviewed indicated that the claimant had essentially failed conservative care. The report from Andrew McKay MD dated 12/7/04 indicated that the claimant was diagnosed with bilateral lumbar facet arthropathy and failed conservative treatment. Thus, the patient has received an adequate trial of care and, apparently, was not responsive to the measures utilized by the chiropractor. An adequate trial of care is defined as a course of two weeks each of different types of manual procedures (4 weeks total), after which, in the absence of documented improvement, manual procedures are no longer indicated (Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993.)

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).

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 use of therapeutic exercises (#97110) was medically necessary from 12/28/04 through 3/16/05. (Dates of service prior to 12/28/05 were designated “fee” in the documentation from the Texas Department of Insurance and the instructions provided in the review question indicated to omit items marked “fee” from comments). 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).

As previously noted, the Philadelphia Panel found that therapeutic exercises were found to be beneficial for chronic, subacute, and post-surgery low back pain. (Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Low Back Pain. Phys Ther. 2001;81:1641-1674).

The use of neuromuscular reeducation (#97112) was not medically necessary from 12/28/04 to 3/16/05, as the medical records did not demonstrate the presence of a definitive neurological deficit that would have necessitated the procedure. (Dates of service prior to 12/28/05 were designated “fee” in the documentation from the Texas Department of Insurance and the instructions provided in the review question indicated to omit items marked “fee” from comments). Neuromuscular reeducation is commonly utilized for post-stroke rehabilitation and is not

commonly utilized for the management of conditions similar to the claimant's. The CPT Code Book defines neuromuscular reeducation as: "neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception". The procedure is utilized to re-establish the neural link between the central nervous system and the motor system after neurological injury. As no definitive evidence of a neural injury was noted, the use of neuromuscular reeducation (#97112) was not medically necessary.

The use of durable medical equipment (#E1399) was not medically necessary from 10/25/04 to 3/16/05. The documentation provided did not support the use of the DME-related products in this case.

Conclusion/Partial Decision to Certify:

1. Dates of service in question are 10/25/04 – 03/16/05. Items in dispute: #97032 (electrical stimulation), #97140 (manual therapy), #99212, #99213, #99214 (OV), #E1399 DME, #97110 (therapeutic exercises), and #97112 (neuromuscular reeducation), which were denied for medical necessity.

The #99213 office visits billed on 1/31/05, 2/16/05 and 3/16/05 were medically necessary.

The use of therapeutic exercises (#97110) was medically necessary from 12/28/04 through 3/16/05.

The use of electrical stimulation (#97032) and manual therapy (#97140) was medically necessary from 10/25/04 to 11/5/04.

Conclusion/Partial Decision to Not Certify:
The office visits (#99212) billed on 11/2/04, 11/9/04, 11/16/04, 11/29/04, 12/5/04, 12/8/04, 12/21/04, and 12/28/04 were not medically necessary.

The office visit (#99214) billed on 12/30/04 was not medically necessary.

The use of electrical stimulation (#97032) and manual therapy (#97140) was not medically necessary from 11/09/04 through 3/16/05.

The use of neuromuscular reeducation (#97112) was not medically necessary from 12/28/04 to 3/16/05.

The use of durable medical equipment (#E1399) was not medically necessary from 10/25/04 to 3/16/05.

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:
CPT Code Book

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

ACOEM Guidelines

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.

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, and the DWC.
Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings / Appeals Clerk
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute

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.

1200195.1
Case Analyst: Cherstin B ext 597