

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 (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 3-31-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The following services and dates of service **were found** to be medically necessary: office visits on 7/14/03; myofascial release on 7/23/03 and 7/30/03; and manual therapy techniques on 8/1/03, 8/4/03, 8/18/03, 8/20/03.

The office visits, ultrasound, electrical stimulation, hot/cold packs therapy, and electrodes rendered from 7/23/03 through 8/20/03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 6th day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

May 20, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

Patient:
TWCC #:
MDR Tracking #: M5-04-2368-01
IRO #: 5251

Ziroc has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Ziroc for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Ziroc has performed an independent review of the care rendered 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The Ziroc health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Ziroc for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was injured on the job in ___. She had some surgical procedures and ongoing symptoms in several areas with a flare-up in symptoms in the right forearm due to continuing to work. At dispute are charges for office visits for 7/14/03, 7/30/03, 8/1/03, 8/4/03, 8/18/03, along with charges for myofascial release (97250) on 7/23/03 & 7/30/03, ultrasound (97035) on 9/23/03, 7/30/03, 8/1/03, 8/4/03, 8/18/03, & 8/20/03, electric muscle stimulation (97014/G0283) on 7/23/03, 7/30/03, 8/1/03, 8/4/03, 8/18/03 & 8/20/03, hot/cold packs (97010) 7/23/03, 7/30/03, 8/1/03, 8/4/03, 8/18/03 & 8/20/03, Electrode (A4556) on 7/23/03, Manual Therapeutic Technique (97140) on 8/1/03, 8/18/03, & 8/20/03.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits, myofascial release, ultrasound, unattended electrical stimulation, hot/cold pack therapy, electrodes and manual therapy.

DECISION

The reviewer agrees with the prior adverse determination regarding all passive modalities including ultrasound, electric stimulation & hot/cold packs, as well as electrodes.

The reviewer agrees with the prior adverse determination regarding office visits of 7/30/03, 8/1/03, 8/4/03, & 8/18/03.

The reviewer disagrees with the prior adverse determination regarding the office visit of 7/14/03.

The reviewer disagrees with the prior adverse determination regarding Myofascial Release on 7/23/03 & 7/30/03.

The reviewer disagrees with the prior adverse determination regarding Manual Therapeutic Technique for the dates of 8/1/03, 8/4/03, 8/18/03 & 8/20/03.

BASIS FOR THE DECISION

Passive modalities (ultrasound (97035), hot/cold packs (97010) and electrical stimulation (97014)) are not indicated for use past 6 weeks of care post-injury without prior approval from the insurance carrier with substantiated medical necessity. There is no documentation included which indicates that pre-authorization was obtained for extended passive care. Additionally, since passive modalities are recommended for denial, the charge for electrodes (A4556) is not indicated.

Of the disputed office visits (99213), documentation existed only for the date of 7/14/03, therefore only that date of service has been recommended for payment. There is no documentation of office visits where the patient met face-to-face with the doctor and a treatment note generated for the other dates of service in question.

The treatment note of 7/23/03 indicates that soft tissue mobilization was performed and therefore myofascial release is recommended for payment on that date (97035). Therapy notes indicate that Soft Tissue Mobilization (STM) was performed on 7/30/03, 8/1/03, 8/4/03, 8/18/03, & 8/20/03. I therefore recommend the approval of myofascial release (97035) for 7/30/03, and Manual Therapeutic Technique (97140) for 8/1/03, 8/4/03, 8/18/03 & 8/20/03.

In summary, the reviewer does not find medical necessity for all passive modalities and electrodes. Documentation of the disputed office visits (99213) exists only for date of service 7/14/03 and the reviewer recommends payment only for that date of service, and denial for all other dates. the reviewer recommends payment for all myofascial release and manual therapeutic technique (97035 & 97140) as documentation does exist for these procedures. In light of the

patient's continued symptoms and exacerbation of symptomology, these charges did appear to be reasonable & necessary.

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee's policy

As an officer of ZRC Services, Inc, dba Ziroc, I certify that there is no known conflict between the reviewer, Ziroc and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Ziroc is forwarding this finding by US Postal Service to the TWCC.

Sincerely,