

MDR Tracking Number: M5-04-2775-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 July 9, 2003.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the issues of medical necessity. The therapeutic exercises, manual traction, myofascial release, and office visit level III **were** medically necessary from 09-16-02 through 12-12-02. The joint mobilization from 09-16-02 through 10-29-02 and the therapeutic exercises, myofascial release and office visits on 10-31-02 and 12-12-02 **were not** medically necessary. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 06-21-04, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Max. Allowable Reimbursement)	Reference	Rationale
08-21-02	95851	\$38.00	\$0.00	No EOB	\$36.00	1996 MFG Rule 133.307 (e)(2)(B)	The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's, therefore this item will be reviewed in accordance with the 96 MFG. Recommend reimbursement of \$36.00.

09-04-02	95851	\$38.00	\$0.00	F	\$36.00	1996 MFG	The requestor submitted relevant documentation to support delivery of services billed. Recommend reimbursement of \$36.00.
09-11-02 09-13-01 09-17-02 09-25-02 10-09-02	97110 x3 97110 x3 97110 x3 97110 x3 97110 x3	\$111.00 \$111.00 \$111.00 \$111.00 \$111.00	\$70.00 \$70.00 \$0.00 \$0.00 \$0.00	F F No EOB	\$35.00	1996 MFG	See rationale below for CPT code 97110.
09-17-02	97122 97250 97265	\$37.00 \$46.00 \$46.00	\$0.00 \$0.00 \$0.00	No EOB	\$35.00 \$43.00 \$43.00	1996 MFG 133.307 (e)(2)(B)	The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's, therefore this item will be reviewed in accordance with the 96 MFG. Recommend reimbursement of \$121.00.
09-18-02	97122	\$37.00	\$0.00	No EOB	\$35.00	1996 MFG 133.307 (e)(2)(B)	The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's, therefore this item will be reviewed in accordance with Medicare Fee Schedule. Recommend reimbursement of \$35.00.
09-18-02	99080-73	\$15.00	\$0.00	U	\$15.00	1996 MFG 133.307 (e)(2)(B)	The TWCC 73 is a TWCC required form and therefore, not subject to an IRO review. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's, therefore, this item will be reviewed in accordance with Medicare Fee Schedule. Recommend reimbursement of \$15.00 in accordance with the 1996 Medical Fee Guideline.
09-19-02	97122 97250	\$37.00 \$46.00	\$0.00	No EOB	\$35.00 \$43.00	1996 MFG 133.307 (e)(2)(B)	The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's therefore these items will be reviewed in accordance with the Medicare Fee Schedule. Recommend reimbursement of \$78.00.
09-23-02	97122 97250 97265 99213	\$37.00 \$46.00 \$46.00 \$51.00	\$0.00	No EOB	\$35.00 \$43.00 \$43.00 \$48.00	1996 MFG 133.307 (e)(2)(B)	The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's therefore these items will be reviewed in

							accordance with the Medicare Fee Schedule. Recommend reimbursement of \$169.00.
10-07-02	97122 97250 97265 99213- MP	\$37.00 \$46.00 \$46.00 \$51.00	\$0.00	No EOB	\$35.00 \$43.00 \$43.00 \$48.00	1996 MFG 133.307 (e)(2)(B)	The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's therefore these items will be reviewed in accordance with the Medicare Fee Schedule. Recommend reimbursement of \$169.00.
TOTAL		\$1233.00					The requestor is entitled to reimbursement of \$659.00.

Rationale for CPT code 97110- 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. Additional reimbursement not recommended.

This Findings and Decision is hereby issued this 5th of November 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

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 in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 08-21-02 through 10-29-02 in this dispute.

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 Order is hereby issued this 5th day of November 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/pr

July 12, 2004

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

Patient:
TWCC #:
MDR Tracking #: M5-04-2775-01
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

Patient underwent physical medicine treatments after injuring cervical spine while lifting 35-50 pound boxes at work on ____.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic exercises, manual traction, myofascial release, joint mobilization and office visits level III from 09-16-02 through 12-12-02, excluding "do not review" services for the dates of 09/17/02, 09/18/02, 09/19/02, 09/23/02, 09/25/02, 10/09/02 and all services performed on 10/07/02.

DECISION

The reviewer agrees with the prior adverse determination regarding all joint mobilizations (97265) and all care after 10/29/02.

The reviewer disagrees with the prior adverse determination regarding all other referenced treatment during the specified dates.

BASIS FOR THE DECISION

All joint mobilizations (97265) are denied due to lack of medical necessity since they would have been a component of the office visits with manipulation (99213-MP). All care after 10/29/02 is denied since no documentation was supplied to support the medical necessity.

Section 413.011, Labor Code, provides that the TWCC must use the reimbursement policies and guidelines promulgated by the Medicare system. The "Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries" Reimbursement Policies applicable to the Texas Medicare system provide as follows: "It is expected that patients undergoing rehabilitative therapy for musculoskeletal injuries in the absence of neurological compromise will transition to self-directed physical therapy within two months..." In this case, most all of the treatment occurred within this time period.

More importantly, the medical records document that the treatment met the statutory requirements since the patient obtained relief, promotion of recovery was accomplished and the employee's ability to return to employment was enhanced. The most graphic evidence that the care was beneficial is the patient's improved cervical range of motion and isometric history detailed in the five examinations performed from 08/21/02 through 10/29/02.

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,