

MDR Tracking Number: M5-04-2841-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 5/3/04, therefore the following date(s) of service are not timely: 4/30/03 and 5/1/03.

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:

- **CPT code 99213:** Level III office visits on 5/16/03 and 6/3/03.
- **CPT code 97110:** Therapeutic exercises from 5/16/03 through 6/11/03.
- **CPT code 97250:** Myofascial release services from 5/16/03 through 6/11/03.
- **CPT code 97750:** Physical performance evaluation on 5/29/03.

The following services and dates of service **were not found** to be medically necessary:

- **CPT code 99213:** Level III office visits from 5/19/03 through 5/28/03 and from 6/4/03 through 6/11/03.
- **CPT code 97112:** Neuromuscular re-education services from 5/16/03 through 6/11/03.
- **CPT code 97122:** Manual traction from 5/16/03 through 6/11/03.
- **CPT code 97265:** Joint mobilization procedures from 5/16/03 through 6/11/03.
- **CPT code 99080:** Special report on 5/16/03.

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 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 to dates of service 5/16/03 through 6/11/03 as outlined above 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 Decision and Order is hereby issued this 9th day of August 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

July 12, 2004
Amended July 27, 2004

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

Patient:
TWCC #:
MDR Tracking #: M5-04-2841-01
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

____, a 32-year-old male, sustained injuries to his low back while on-the-job as a mechanic on _____. This is a gentleman who has had a prior low back injury requiring surgery in 1995. He was pulling/lifting cases of oil, fluid antifreeze etc. from shelves when he developed back pain. Since that time he has had numerous therapeutic interventions, including physical therapy, chiropractic care, epidural steroid injections, work hardening and pain management. He has been assessed by a number of Independent evaluators, who disagree as to his status regarding maximum medical improvement, as well as treatment options. According to the most recent documentation, he persists with low back pain with radiation into the right lower leg. He has had lumbar and thoracic MRIs, which what unremarkable aside from a L5/S1 posterior central annular tear with 2 mm symmetric annular bulge and associated mild degree of facet arthrosis changes. EMG/NCV studies have also been performed; these are negative as of January 2003.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits, therapeutic exercises, neuromuscular re-education, manual traction, myofascial release, joint mobilization, special reports and physical performance examination from 05/16/03 through 06/11/03.

DECISION

The reviewer disagrees with the prior adverse determination regarding two of the office visits (99213): on 5/16/03 and 6/3/03, therapeutic exercises (97110) for all dates of service, myofascial release (97250) for all dates of service and the physical performance evaluation (97750) for 5/29/03.

The reviewer agrees with the prior adverse determination regarding all other services in dispute.

BASIS FOR THE DECISION

The first question is whether or not the patient requires any type of ongoing care. The patient has a number of fairly significant complicating factors: his occupation as a mechanic with its high predisposition for "industrial back", the presence of a prior surgical situation, the lack of response to initial intervention, marginal response to secondary level interventions (ESI, etc). This tends to establish that patient is not simply suffering from an uncomplicated "sprain/strain" injury. Two separate designated Doctor evaluations were performed, each indicating that the patient was not at MMI and needed to pursue ongoing interventional measures. The evaluations reported by

these designated doctors appear more credible than the RME / peer reviewing doctors. Ongoing care appears medically necessary.

Code 99213:

The patient was essentially undergoing a rehabilitation/strengthening program for his lower back. 99213 history and exam level requirements would not appear to be relevant (nor are they satisfied according to the documentation available) for the monitoring of such a program on each encounter, particularly as the doctor had been treating the patient for such an extended period of time. Standard of care would be for simple monitoring of the patient every two or three weeks to establish benchmarks to see how he was coming along with his rehabilitation. The first date of service that is disputed is 5/16/03, so this would be an appropriate starting point. A follow-up office visit on 6/3/03 following his functional performance evaluation is also appropriate.

Code 97110:

The patient had exhausted first level interventional care and had progressed to a more active exercise platform. This is an appropriate treatment within accepted standards of care, especially given the complicating factors and intractable nature of this patient's problem.

Code 97250:

The records demonstrate an ongoing degree of motion loss, hypertonicity and stiffness along with this gentleman's pain.

Code 97750-PPE:

The patient was involved in primarily an active regimen of treatment. Physical assessment to establish appropriate benchmarks, monitoring of the patient's progress and setting treatment goals/treatment planning is within accepted standards of care and is an appropriate and medically necessary procedure.

Neuromuscular reeducation (97112), manual traction (97122), joint mobilization (97265):

There is no documentation available to support what type of "neuromuscular reeducation" was performed, its necessity or outcomes associated with this procedure.

Manual traction/joint mobilization would seem to be duplicative procedures, both within themselves and especially when performed in conjunction with massage/myofascial release. They are certainly unnecessary at such a late stage in the patient's injury stage and redundant in the face of the other more active exercise interventions.

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,

References:

Hansen DT: Topics in Clinical Chiropractic,

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters,

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms,