

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. This dispute was received on 5-24-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, joint mobilization, myofascial release, therapeutic exercise, manual therapy, muscle testing, FCE, and ROM measurements from 7-31-03 through 11-14-03 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees 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 7-27-04, 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.

In response received on 6-3-04 the insurance carrier submitted a TWCC 21 dated 4-7-04. This TWCC 21 disputed RSD tenosynovitis, right radius fracture and muscle spasms as not related to the compensable injury. However, the CCH held on 5-27-04 stated that reflex sympathetic dystrophy, radial fracture and crush injury of the right hand were compensable. There is no indication in TWCC records that an appeal has been filed.

- CPT code 95999 for date of service 7-16-03 was denied by the carrier with an "F" denial code. The 1996 Medical Fee Guideline, part VI of the General Instructions states that "a MAR is listed for each code excluding documentation of procedure (DOP) codes and HCPCS codes. HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate." The carrier paid \$384 for this code on 7-16-03. Relevant information (i.e. redacted EOBs- with same or similar services- showing amount billed is fair and reasonable) was not submitted by the requestor to confirm that \$384 is their usual and customary charge for this service.  
**Therefore, reimbursement is not recommended.**

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- CPT Code 97140-QU for dates of service 8-7-03, 8-11-03 and 8-12-03 was denied by the carrier with “F”. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. According to Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or (2) health care provider’s usual and customary charge. **Reimbursement is recommended in the amount of \$90.75.**
- CPT Code 97032 QU for date of service 8-26-03 was billed by the requestor and denied by the carrier. Neither the requestor nor the respondents submitted EOB’s and did not timely respond to the request for additional information. These dates of service will be reviewed in accordance with Rule 134.202. According to Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or (2) health care provider’s usual and customary charge. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$19.89.**
- CPT Code 99213 QU for date of service 8-27-03 was billed by the requestor and denied by the carrier. Neither the requestor nor the respondents submitted EOB’s and did not timely respond to the request for additional information. These dates of service will be reviewed in accordance with Rule 134.202. According to Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or (2) health care provider’s usual and customary charge). Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$ 62.81.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees from dates of service 8-7-03 through 8-27-03 as outlined above:

- 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 26<sup>th</sup> day of October 2004.

Donna Auby  
 Medical Dispute Resolution Officer  
 Medical Review Division

September 2, 2004

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

Patient:  
TWCC #:  
MDR Tracking #: M5-04-3198-01  
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

Based on the initial examination of Dr. K, this patient appears to have sustained a crush injury to the hand. No fracture as seen on x-ray and at a later date a MRI was read as normal. Dr. C, a referral physician, remarked that there was an intraarticular fracture of the right radius. He also felt that the patient had RSD. In a later note, Dr. K stated that he did not think the patient had any of these things. Dr. K's diagnoses were synovitis and tenosynovitis of the hand and wrist, neuritis and spasm of muscle. The plan of care was passive and active physical therapy. No chiropractic care appears to have been administered. The patient was released to light duty with restrictions on 10/04/03 by Dr. K. Evidently the patient was seen by Dr. T, a hand surgeon, and was felt able to work full duty on 10/9/03. Dr. T's report, a TWCC-73, was unavailable for review. Clinically there is nothing significant within the documentation that would suggest that this is a complicated case requiring extended treatment or complicated treatment and testing.

#### DISPUTED SERVICES

Under dispute is the medical necessity of office visits, joint mobilization, myofascial release, therapeutic exercise, manual therapy, muscle testing, FCE and ROM measurements from 7/31/03 through 11/14/03.

## DECISION

The reviewer agrees with the prior adverse determination.

### BASIS FOR THE DECISION

One can look line by line to see if the office notes justify the charges rendered and/or to see if the care delivered was efficacious. If that care rendered was not documented as being efficacious, then all else is moot. The literature shows very little efficacy of this type of treatment for these diagnoses. In reviewing thermo and muscle testing in this case, the reviewer found that the patient either got worse or hardly changed at all. A reasonable trial of care is four weeks. If the patient fails to respond significantly (by 50%) then care should be terminated and other options entertained. Based on the documentation presented for review, the care rendered failed to do this and therefore similar care after the initial four weeks is unsubstantiated as being medically necessary. Because this patient was initially seen by this provider on 06/25/03, care after 07/25/03 is considered medically unnecessary and therefore would exclude all care in regards to this review as being medically unnecessary.

Guidelines utilized in this decision included the TWCC-STG, effective date 02/01/00 and Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, 1994.

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,