

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-2106.M5**

MDR Tracking Number: M5-04-3511-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 6-14-04.

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, therapeutic procedures, group therapeutic procedures, manipulation, unlisted therapeutic procedures, massage, physical performance test, mechanical traction and supplies and materials from 8-1-03 through 9-29-03 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 9-13-03, 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.

- Regarding CPT Code 97110 for dates of service 6-17-03, 6-18-03, 6-19-03, 6-23-03, 6-24-03, 7-1-03, 7-2-03, 7-3-03, 7-7-03, 7-9-03, 7-11-03, 7-16-03, 7-21-03, 7-23-03, 7-25-03 and 7-28-03: 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.**

- CPT Code 97024 for date of service 6-17-03 was denied with an F. Rule 133.304(c) states: At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. **Recommend reimbursement of \$21.00.**
- Regarding CPT Code 97014 for date of service 6-18-03 was denied with an "F". Rule 133.304(c) states: At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. **Recommend reimbursement of \$15.00.**
- CPT Codes 97265 and 97250 for date of service 6-19-03 were billed by the requestor and denied by the carrier. Neither the requestor nor the respondents submitted EOB's for these services and did not timely respond to the request for additional information. These dates of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$86.00**
- CPT Code 97150 for date of service 6-24-03, 7-2-03, 7-9-03, 7-11-03, 7-16-03, 7-21-03, 7-23-03 and 7-28-03 was denied with an "F". Rule 133.304(c) states: At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. **Recommend reimbursement of \$216.00.**

- The carrier denied CPT Code 99080-73 for dates of service 6-25-03 and 10-23-03 with an N and a G, however, the TWCC-73 is a required report. The Medical Review Division has jurisdiction in this matter and, therefore, per Rule recommends reimbursement. Requester submitted relevant information to
- support delivery of service. Per 134.1(c) **recommend reimbursement of CPT Code 99080-73 for two dates of service for a total of \$30.00.**
- CPT Code 97750-MT for dates of service 6-27-03, 6-30-03, 7-15-03, and 7-29-03 was denied with an F. Rule 133.304(c) states: At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. **Recommend additional reimbursement of \$1,376.00.**
- CPT Code 99213 for date of service 7-7-03 and CPT Code 99212 for date of service 10-14-03 was billed by the requestor and denied by the carrier. Neither the requestor nor the respondents submitted EOB's for these services and did not timely respond to the request for additional information. These dates of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$89.91.**
- CPT Code 97750-MT for date of service 8-19-03 and 9-30-03 was billed with an invalid CPT Code. In accordance with 134.202(b): for billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies. **No reimbursement recommended.**
- CPT Code 95851 was denied with a K denial code for dates of service 8-19-03 (5 units) and 9-30-03 (3 units). The requester has furnished information stating that this was not performed by a physical or occupational therapist and therefore should be reimbursed. **Recommend reimbursement of \$244.88.**

Pursuant to 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) 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 13<sup>th</sup> day of October 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

August 9, 2004

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

Patient:  
TWCC #:  
MDR Tracking #: M5-04-3511-01  
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

This 51-year-old female fell while at work, landing on her abdomen. She subsequently developed pain in her knees, shoulders, elbows, back and neck and initially received care at Concentra Medical Center consisting of medication therapy only. She eventually changed to a doctor of chiropractic, and then received extensive physical therapy and rehabilitative treatments.

#### DISPUTED SERVICES

Under dispute is the medical necessity of office visits (99215-25), therapeutic procedures (97110), group therapeutic procedures (97150), manipulation (98943), office visits (99211-25), unlisted therapeutic procedures (97139-EU), massage (97124), physical performance test (97750), mechanical traction (97012) and supplies and materials (99070) from 08/01/03 through 09/29/03.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

For all practical purposes, no actual treatment records were supplied since the treating doctor's daily progress notes were computer-generated, essentially verbatim from day to day and practically super imposable upon each other. Other than the patient's pain ratings on each date of service (DOS) and the 06/25/03, 08/19/03 and 09/30/03 examinations, there were no medical records authored by the treating doctor on which to rely to properly evaluate the medical necessity for the treatment in question.

In regard to the patient's pain ratings, every rating was either a 6/10 or a 7/10 ("10" representing the worst pain possible from a scale of 1-10) during the entire treatment time frame from 06/18/03 (at the initiation of care) to 08/19/03 (near the initiation of the care in dispute) to 09/22/03 (near the termination of the care in dispute). Those constant and unchanged ratings document that the treatment in question failed to relieve the patient's pain and thus did not satisfy the statutory criteria outlined in Texas Labor Code 408.021.

In regard to the examinations, the one performed on 08/19/03 (closest to the initiation of the care in dispute) and the examination performed on 09/30/03 (at the termination of the care in dispute) failed to show any significant functional improvement after the care in question was rendered. In fact, some of the ranges of motion actually decreased during this period of time. Therefore, since there is no documentation that the treatment satisfied the criteria of Texas Labor Code 408.021 by promoting recovery, it was medically unnecessary.

And finally, the patient's constant pain ratings should have signaled the need for a change in treatment. Other than the computer-generated treatment records claiming that manipulation was performed, no doctor notes were furnished to document that manipulation was actually

performed or which specific articulations were manipulated. According to the AHCPR<sup>1</sup> guidelines, spinal manipulation was the only recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain, and several randomized studies<sup>2 3 4</sup> have proven the effectiveness of spinal manipulation for patients with cervical spine symptoms and conditions. Based on those studies, it is difficult to understand why a doctor of chiropractic would proceed with a host of other therapies while withholding – or at least failing to specifically document – a proper regimen of spinal manipulation. It is also very difficult to understand why this acute patient was immediately placed on therapeutic exercises, without the benefit of passive modalities initially, and encouraged to continue those procedures when the “Therapeutic Procedures 1 Chart” notes repeatedly indicated that the patient was having immense difficulty performing the assigned tasks due to her pain. These forms included comments such as “protocol altered today due to tolerance” and “patient did as much as she could physically endure” and “pain in right knee did not allow her to complete....” At the very least, these notes documented that a change in treatment should have been considered.

(Reviewer note: Even had these services been determined to be medically necessary, the records in this case revealed that the treating doctor reported a minimal evaluation and management code (E/M [99211]) on the same visit that he also reported a chiropractic manipulative therapy (CMT) service. The medical necessity of this cannot be supported, as the E/M service was a component of CMT and performing both would be duplicative.)

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,

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<sup>1</sup> Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.

<sup>2</sup> Hurwitz EL, Morgenstern H, Harber P, Kominski GF, Yu F, Adams AH. A randomized trial of chiropractic manipulation and mobilization for patients with neck pain: clinical outcomes from the UCLA neck-pain study. *Am J Public Health.* 2002 Oct;92(10):1634-41.

<sup>3</sup> Hoving JL, Koes BW, de Vet HC, van der Windt DA, Assendelft WJ, van Mameren H, Deville WL, Pool JJ, Scholten RJ, Bouter LM. Manual therapy, physical therapy, or continued care by a general practitioner for patients with neck pain. A randomized, controlled trial. *Ann Intern Med.* 2002 May 21;136(10):713-22.

<sup>4</sup> Gross AR, Hoving JL, Haines TA, Goldsmith CH, Kay T, Aker P, Bronfort G, Cervical overview group. Manipulation and Mobilisation for Mechanical Neck Disorders. *Cochrane Database Syst Rev.* 2004;1:CD004249.