

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, electrical stimulation, massage therapy, unlisted therapeutic procedures, and physical performance test from 6-16-03 through 9-4-03 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 7-19-04, 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 carrier denied CPT Code 98943 for dates of service 6-16-03, 6-17-03, 6-20-03, 6-26-03, 6-27-03, 7-3-03, 7-10-03, 7-17-03, 8-1-03, 8-5-03 with an "O" – Denial after reconsideration. However, this is not a valid CPT code under either the 1996 Medicare Fee Guidelines or Medicare. Rule 134.202 (b) which states: "for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." **No reimbursement is recommended.**
- The carrier denied CPT Code 99455 for dates of service 6-17-03 and 7-17-03. This is a work related or medical disability examination by the treating doctor for a Maximum Medical Improvement/Impairment Rating. The disputed services will be reviewed in accordance with the 1996 Medical Fee Guidelines. According to the Ground Rules for Evaluation and Management a review of a report will be billed \$50.00 each. **Recommend reimbursement of \$100.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees from 6-17-03 through 7-17-03 as outlined above in this dispute,

- 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;
- 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 19th day of October 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

September 8, 2004
Amended September 24, 2004

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

Patient:
TWCC #:
MDR Tracking #: M5-04-3512-01
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.

RECORDS REVIEWED

PT notes of the Montana Rehabilitation Center, PT notes of Dr. G, DC, Peer review of Dr. B, MD, report of Dr. K, DO.

CLINICAL HISTORY

This patient was working for an auto company when he lifted a floor jack and he felt a pain in the left side of his back. Records indicate that he also had some boxes to fall on him while he was working the jack, but no indication of the size of the boxes or of what the boxes were constructed from. He began treating under the care of Dr. M, DC for the injury about 8 weeks after the initial injury and again changed doctors to Dr. G, DC on May 28, 2003. He was treated with chiropractic care and physical medicine. He continued under the care of this clinic through his MMI date. MRI of the lumbar spine was performed and records indicate that there was degeneration of the spine lacking herniation of a disc. ___ was found to be at MMI with 5% impairment as of March 18, 2003 with 5% impairment by designated doctor Dr. K, DO. A note in the file from the patient indicates he feels he was discriminated against. The designated doctor's report was disagreed with by Dr. G, DC. A file review by Dr. B, MD was performed, but there is not a date found on the record.

DISPUTED SERVICES

The carrier has denied the medical necessity of office visits, electrical stimulation, massage therapy, unlisted procedures and physical performance testing from June 16, 2003 through September 4, 2003.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The care rendered on the case was clearly excessive. The patient was not demonstrated to have a pathology of the spine other than of a somatic dysfunction variety and the care that is disputed took place well in excess of a year after the injury date. The patient had been found at MMI several months before this and there is no documentation to indicate that ongoing care was a result of the date of injury. The reviewer is unable to find any form of treatment guideline that would validate the care that was rendered and finds the care to be neither reasonable nor 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,