

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: 453-05-4327.M5

MDR Tracking Number: M5-04-3638-01

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, 133.307 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 06-28-04.

The requestor submitted an amended table of disputed services on 11-15-04 which is used in the review by the Medical Review Division.

The IRO reviewed office visits, myofascial release, therapeutic exercises, massage therapy, manual therapy techniques, electrical stimulation, electrodes, ultrasound, electrical stimulation-unattended, neuromuscular re-education and paraffin bath rendered from 07-09-03 through 03-26-04 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. 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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** 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 09-02-04, 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.

CPT code 99214 date of service 08-21-03 denied with denial code "G/U454" (this visit is included in the value of the surgery or anesthesia procedure). Per Encoder.Pro/Ingenix CPT code 99214 is not global to the surgery or anesthesia services billed. Reimbursement is recommended per Rule 134.202(b). The MAR is \$92.30 (\$73.84 X 125%). The requestor billed **\$77.00** and therefore is the recommended reimbursement.

CPT code J3490 dates of service 08-21-03 and 02-19-04 denied with denial code “N/X322” (documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge). Documentation submitted by the requestor meets

criteria. Reimbursement is recommended per Rule 134.202(b) in the amount of **\$60.00** (\$30.00 X 2 DOS).

CPT code J3490 date of service 09-02-03 is listed on the table of disputed services. The EOB from the carrier indicates service has been paid in full. The requestor was contacted and payment was verified. No dispute exists.

CPT code 99080-73 date of service 07-09-03 denied with denial code “V” (unnecessary medical with peer review) and date of service 12-29-03 denied with denial code “U/X375” (unnecessary medical treatment). Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$30.00** (\$15.00 X 2 DOS).

CPT code 99212 dates of service 02-03-04, 02-19-04 and 03-18-04 denied with denial code “G/U454” (this visit is included in the value of the surgery or anesthesia procedure). Per Encoder.Pro/Ingenix CPT code 99212 is not global to the surgery or anesthesia services billed. Reimbursement is recommended per Rule 134.202(b). Reimbursement in the amount of **\$132.48** is recommended ( $\$35.33 \times 125\% = \$44.16 \times 3 \text{ DOS}$ ).

CPT code J2000 date of service 02-03-04 denied with denial code “G/B377” (this is a bundled procedure. No separate payment allowed). The carrier per Rule 134.202(a)(4) did not specify which service code J2000 was global to. Reimbursement is recommended in the amount of **\$4.46** ( $\$3.57 \times 125\%$ ).

CPT code J2001 date of service 03-18-04 denied with denial code “G/B377” (this is a bundled procedure. No separate payment allowed). The carrier per Rule 134.202(a)(4) did not specify which service code J2000 was global to. Reimbursement is recommended in the amount of **\$1.10** ( $\$0.88 \times 125\%$ ).

This Findings and Decision is hereby issued this 26<sup>th</sup> day of January 2005.

Debra L. Hewitt  
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 Medicare program reimbursement methodologies effective August 1,

2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 07-09-03 through 03-26-04 in this dispute.

This Order is hereby issued this 26th day of January 2005.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/dlh  
Enclosure: IRO Decision

August 30, 2004

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

Patient:  
TWCC #:  
MDR Tracking #: M5-04-3638-01  
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

was injured on the job as of \_\_\_\_\_. She was a customer serve representative at \_\_\_\_\_ for three years. Her job consisted of high-level data entry and observation of her video display. She is a right-handed mouse user. She related a history of repetitive use trauma to both upper extremities and her neck.

Her initial complaints were of left distal forearm and wrist pain, and right upper extremity pain. She felt radiating pain into the shoulders and neck bilaterally, worse on the left. She had

numbness into the 2,3,4 digits bilaterally, worse on the left. Her initial pain rating was 8/10. She had no preexisting or contributory medical leading up to her date of injury. Her initial/working diagnosis as outlined by the treating physician was:

1. Left cubital tunnel syndrome
2. Left pronator syndrome
3. Bilateral carpal tunnel syndrome
4. Myofasciitis

Her treatment consisted of passive modalities and rehabilitative techniques. She underwent EMG/NCV testing and had confirmed bilateral CTS. She underwent wrist tendon injections and trigger point injections. She had a left CT release and post surgical OT with an O.T.R. She then underwent left cubital tunnel release/ulnar nerve transposition, and had post surgical allergic reaction to tape and subsequent infection, prolonging her recovery. She developed clinical depression as related to the pain and disability associated with the work injury. She was seen for this as well. She had a prolonged recovery.

She underwent RME at the carrier's request in June 22, 2004 and found not to be at MMI. The RME doctor stated that all care related to the carpal tunnel and cubital tunnel diagnoses had been reasonable. He wished not to comment on the diagnosis of myofasciitis and neck pain. He stated he could not understand how her neck could be involved. She underwent designated doctor examination July 5, 2004 and was found not to be at MMI.

#### DISPUTED SERVICES

Under dispute is the medical necessity of office visits, myofascial release, therapeutic exercises, massage therapy, manual therapy techniques, electrical stimulation, electrodes, office visit, ultrasound, electrical stimulation unattended, neuromuscular re-education and paraffin bath from 7-9-2003 through 3-26-2004.

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

This patient was seen in a multi-discipline clinic. She was attended by Dr. Brad Burdin who is board certified in Chiropractic Neurology. This case was documented extremely well and all providers attending to this patient appear to have worked as a team, and in the best interest of this patient. The patient's injuries were multiple and complicated. The treating doctor did a fine job of managing this case. Based on the documentation presented, the only explanation for denying the dates of service in question were based on a Paper Peer Review, performed by Professional Reviews, Inc., in the state of Georgia. There was no direct communication by the peer review doctor and Dr. Burdin, or any other provider caring for \_\_\_\_\_. The denial was based on the limited documentation provided to the peer review doctor by the carrier. Moreover, this case was reviewed via RME by a board certified orthopaedic surgeon on June 22, 2004. opining care had been reasonable and necessary and that the patient was still not at MMI. Further, the patient then underwent a designated doctor examination by another medical physician on July 5, 2004, stating

the patient was not at MMI. Additionally, the diagnosis of cervical/thoracic myofasciitis is a well-documented sequela to carpal tunnel syndrome. This condition is frequently seen associated with upper extremity overuse syndromes.

The documentation of this case is above the general standard, and the protocols used are the standard of care generally associated with a case of this magnitude. Moreover, when applying Texas Labor Code 408.021 relating to medically necessary care, all points defined within the definition of the Code were met throughout the length of the case.

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,

Nan Cunningham  
President/CEO

CC: Ziroc Medical Director