

MDR Tracking Number: M5-04-3749-01

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 06-29-04.

The IRO reviewed manual therapy, electrical stimulation, therapeutic procedures, neuromuscular stimulation and office visits rendered from 09-03-03 through 10-30-03 that were denied based upon "V".

The IRO determined that the manual therapy, electrical stimulation, therapeutic procedures and office visits **were** medically necessary. The IRO determined that the neuromuscular stimulation **was not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of 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 11-09-04, 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 99212 dates of service 09-09-03 and 09-11-03 denied with denial code "H" (reimbursement is based upon half of the fee amount pending decision of audit or review). Per Rule 133.303(e) the respondent within seven days of completing an onsite audit shall take final action on the bill, consistent with the results of the audit. The respondent did not take final action within the time frame per Rule 133.303(e). Additional reimbursement is recommended per the Medical Fee Guideline effective 08-

01-03 in the amount of \$46.42 ($\$37.13 \times 125\% = \46.41×2 minus carrier payment of \$46.40).

CPT code 97110 dates of service 09-09-03 and 09-11-03 denied with denial code "H" (reimbursement is based upon half of the fee amount pending decision of audit or review). 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 97112 dates of service 09-09-03 and 09-11-03 denied with denial code "H" (reimbursement is based upon half of the fee amount pending decision of audit or review). Per Rule 133.303(e) the respondent within seven days of completing an onsite audit shall take final action on the bill, consistent with the results of the audit. The respondent did not take final action within the time frame per Rule 133.303(e). Reimbursement per the Medical Fee Guideline effective 08-01-03 is \$36.69 ($\$29.35 \times 125\%$). The requestor only billed \$35.00 for each date of service. Additional reimbursement is recommended in the amount of \$35.00 ($\$35.00 \times 2 = \70.00 minus carrier payment of \$35.00).

CPT code 97140 date of service 09-11-03 denied with denial code "H" (reimbursement is based upon half of the fee amount pending decision of audit or review). Per Rule 133.303(e) the respondent within seven days of completing an onsite audit shall take final action on the bill, consistent with the results of the audit. The respondent did not take final action within the time frame per Rule 133.303(e). Additional reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of \$16.95 ($\$27.12 \times 125\% = \33.90 minus carrier payment of \$16.95).

CPT code 97140-59 dates of service 09-09-03 and 09-11-03 denied with denial code "H" (reimbursement is based upon half of the fee amount pending decision of audit or review). Per Rule 133.303(e) the respondent within seven days of completing an onsite audit shall take final action on the bill, consistent with the results of the audit. The respondent did not take final action within the time frame per Rule 133.303(e). Additional reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of \$33.90 ($\$27.12 \times 125\% = \$33.90 \times 2 \text{ DOS} = \67.80 minus carrier payment of \$33.90).

CPT code 97032 dates of service 09-09-03 and 09-11-03 denied with denial code "H" (reimbursement is based upon half of the fee amount pending decision of audit or review). Per Rule 133.303(e) the respondent within seven days of completing an onsite audit shall take final action on the bill, consistent with the results of the audit. The respondent did not take final action within the time frame per Rule 133.303(e). Additional reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of \$20.68 ($\$16.54 \times 125\% = \$20.68 \times 2 \text{ DOS} = \41.36 minus carrier payment of \$20.68)

Review of CPT code 97140 revealed that neither the requestor nor the respondent submitted a copy of an EOB. The requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB in accordance with Rule 133.307(e)(2)(B). No reimbursement is recommended.

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 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 09-03-03 through 10-30-03 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 Findings and Decision and Order are hereby issued this 6th day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

September 27, 2004

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

Patient:
TWCC #:
MDR Tracking #: M5-04-3749-01
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

Enclosed and reviewed records included office notes of Dr. H on 08/06/03, 08/09/03 and 10/16/03. Physical therapy notes from ___ are from 09/03/03 through 10/30/03. There are notes from Dr. F, DO on the dates of 10/22/03. There is a designated doctor's report dated 10/27/03 from Dr. B, MD. A lumbar MRI report is dated 09/06/03. There are notes from Dr. A, MD on ___, 07/08/03, 07/22/03, and 08/18/03. Clear Lake Emergency notes from 06/27/03 were provided, and Neuroevaluation notes from Dr. L, MD on 01/05/04 were also provided. A peer review from Dr. M, DC was done on 11/05/05.

CLINICAL HISTORY

___ was injured on the job on ___. From the notes provided by the requestor, this patient hurt himself while attempting to lift a 45-pound bag of dog food, causing immediate low back pain. He was sent to Dr. A, MD the same day he was prescribed physical therapy and medication. He switched treating doctors to Dr. H, DC due to reported lack of improvement. He received therapy from ___, PT from 09/03/03 through 10/30/03. Insurance has withheld payment of some procedures during these dates as unnecessary due to peer review. Review of the peer review finds that all therapy and manipulation should end on 10/15/03 as he states the diagnosis is a simple lumbar sprain. The only procedure that he disallows is neuromuscular reeducation.

DISPUTED SERVICES

Under dispute is the medical necessity of manual therapy, electrical stimulation, therapeutic procedures, neuromuscular stimulation and office visits from 09/03/03 through 10/30/03.

DECISION

The reviewer disagrees with the prior adverse determination regarding manual therapy, electrical stimulation, therapeutic procedures and office visits.

The reviewer agrees with the prior adverse determination regarding neuromuscular stimulation.

BASIS FOR THE DECISION

This patient was initially diagnosed as having a sprain, but later showed a 3 mm disc bulge at L5/S1 pressing against the left nerve root. While it is impossible to say whether or not the bulge was preexisting, it is reasonable to believe that it is a complicating factor and would reasonably affect his rate of recovery negatively. As we are only talking about a couple of weeks, it is well within reasonable limits. The reviewer does agree that neuromuscular reeducation is not medically necessary or appropriate in this 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,