

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

SOAH DOCKET NO. 453-05-3063.M5

MDR Tracking Number: M5-04-4009-01

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. The dispute was received on 7-23-04.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date of service in dispute. The Commission received the medical dispute resolution request on 7/23/04, therefore the following date of service is not timely: 7/22/03.

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** 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.

The IRO has determined that the therapeutic procedures, diathermy, chiropractic manipulative treatments, office visits, Delorme muscle testing, range of motion measurements and report, mechanical traction, therapeutic exercises, supplies and materials, and group therapeutic procedures that were denied with "V" and rendered from 8/1/03 through 12/23/03 were medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

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 August 13, 2004, 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 97265 dates of service 7/23/03, 7/24/03, 7/25/03, 7/28/03, 7/29/03, 7/30/03, and 7/31/03 were denied by the carrier with “O” (denial after reconsideration), and “D” (duplicate bill). Copies of the HCFAs in file are stamped “2nd request for reconsideration.” The respondent raised no other reasons for denying reimbursement for this service. **Reimbursement is recommended in the amount of \$301.**

CPT code 97024 for date of service 8/1/03 was denied by the carrier with “N”, not appropriately documented. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. **Reimbursement is recommended in the amount of \$5.53.**

CPT code 97139-EU for dates of service 8/20/03, 8/22/03, 10/2/03, 10/3/03 was denied by the carrier with “N”, not appropriately documented. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. **Reimbursement is recommended in the amount of \$91.25**

CPT code 97139-EU for date of service 10/1/03 was denied by the carrier with "F", fee guideline reduction. However, no payment was made. The respondent raised no other reasons for denying reimbursement for this service. **Reimbursement is recommended in the amount of \$18.25.**

CPT code 97124 for dates of service 8/20/03 and 10/2/03 was denied by the carrier with "F", fee guideline reduction. However, no payment was made. The respondent raised no other reasons for denying reimbursement for this service. **Reimbursement is recommended in the amount of \$ 51.38.**

CPT code 97750 for date of service 8/26/03 was denied by the carrier with “F”, fee guideline reduction. The requestor billed \$267.20 for 8 units. The carrier paid \$200. In accordance with Rule 134.202 (c), **additional reimbursement is recommended in the amount of \$67.28.**

CPT code 99080-73 for date of service 9/30/03 was denied by the carrier with “G”, unbundling. However, in accordance with Rule 129.5, the TWCC 73 is a required form. The Medical Review Division has jurisdiction in this matter and, therefore, **recommends reimbursement in the amount of \$15.**

CPT code 99070 for dates of service 8/27/03 and 10/1/03 was denied by the carrier with “G”, unbundling. However, the carrier did not specify what code this service was global to in accordance with Rule 133.304 (c). Since the carrier did not provide a valid basis for this service, **reimbursement is recommended in the amount of \$50.00.**

CPT code 97110 for dates of service 7/24/03 through 10/31/03 (except when denied for medical necessity): Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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 MDR 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.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees as follows:

- 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 (c);
- in accordance with TWCC reimbursement methodologies regarding Work Status Reports for dates of service after August 1, 2003 per Commission Rule 134.202 (e)(8);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 7/23/03 through 12/23/03 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 Decision and Order is hereby issued this 8th day of November 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

September 24, 2004

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

Patient:
TWCC #:
MDR Tracking #: M5-04-4009-01
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 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

Records provided for review include office notes of Back and Joint Clinic, Physical therapy notes Scott and White Clinic, Surgical note, MRI right shoulder, EMG upper extremity, Neurology consult note, multiple prescriptions for durable medical goods, TWCC related/required forms, position paper from treating doctor clinic, position paper from carrier, pain management/mental health note.

CLINICAL HISTORY

___ was injured on the job on ____. Direct injury occurred to the right shoulder while lifting a five-gallon bucket. Treatment consisted of physical therapy, pain medications chiropractic manipulation, home management, activity modification and ultimately surgery. She continued with post surgical rehabilitation.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic procedure, diathermy, chiropractic manipulation treatment, office visits, delorme muscle testing, ROM measures and report,

mechanical traction, therapeutic exercises, supplies and materials, therapeutic procedures and group therapeutic procedures from 08/01/03 through 12/23/03.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

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 progress of the patient is well documented not only in the subjective history of the patient, but also in the functional testing/outcomes of the patient. The treating doctor did a fine job of managing this case.

Again, the documentation 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.

There is some question as to the need for manipulation to the cervical spine as well as mechanical traction to the cervical spine. The documentation of the injury is clearly related to the right shoulder; however, frequently encountered sequela to a shoulder injury of this nature is to have compensatory problems associated with the neck. This is clearly the case here. Treatment to the neck is reasonable with the means administered 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,