

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

SOAH DOCKET NO. 453-05-2758.M5

MDR Tracking Number: M5-05-0004-01

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 (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 August 25, 2004.

The 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 the office visits, aquatic therapy with therapeutic exercises, massage including effleurage, petrissage and/or tapotement, electrical stimulation, therapeutic exercises, manual therapy techniques, magnetic resonance imaging, spinal canal and contents, lumbar without contract material rendered on 11/5/03, 11/10/03-11/20/03, 11/21/03 and 12/6/03-12/19/03 were not found to be medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 September 17, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	MAR	Paid	EOB Denial Code	Rationale
11/5/03 11/21/03	99080-73	\$15.00 \$15.00	\$15.00 \$15.00	\$0.00 \$0.00	U U	The carrier denied CPT Code 99080-73 with a U for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. The requestor is entitled to reimbursement in the amount of \$30.00.

11/5/03	99070	\$32.00	DOP	\$0.00	No EOB	Review of the HCFA 1500 revealed the requestor billed for HCPCs code E0943, in the sum of \$32.00, rendered on 11/5/03. The carrier audited and denied HCPCs code E0943. Therefore, the requestor did not submit relevant information to support that the services noted on the table were billed to the carrier. Reimbursement is not recommended.
TOTAL		\$62.00	\$30.00	\$0.00		The requestor is entitled to reimbursement in the amount of \$30.00.

ORDER

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 in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(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 11/5/03 and 11/21/03 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 Order is hereby issues this 22nd day of October 2004.

Margaret Q. Ojeda
 Medical Dispute Resolution Officer
 Medical Review Division

MQO/mqo

Otober 19, 2004

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

Patient:
 TWCC #:
 MDR Tracking #:
 IRO #:

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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

The documentation presented states the patient sustained a work-related injury on ___ while lifting a heavy box of lab equipment while working for the ___. The patient initially was treating with Dr A, D.D. and then was treating with Dr. H for her work-related injury. The documentation presented consists of treatment dates in dispute and reports from the provider and the carrier. The patient was referred for an MRI of the lumbar spine on 12/06/03 that displayed a 4-5 mm central disc protrusion to early herniation that did note annular tears without nerve root involvement. The prior MRI dated 08/18/01 displayed mild disc desiccation and bulging at the L5/S1 level. The patient was put at MMI for her work-related injury by Dr. H on 01/02/02 with a 6% whole person impairment rating.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits, aquatic therapy with therapeutic exercises, massage including effleurage, petrissage and/or tapotement, electrical stimulation, therapeutic exercises, manual therapy techniques, magnetic resonance imaging, spinal canal and contents, lumbar without contrast material for 11/05/03, 11/10/03 – 11/20/03, 11/21/03 and 12/06/03 – 12/19/03.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Current studies out of Madigan Medical Center, Vanderbilt University, Orthopedic Technology and the North American Spine Society research department all concur that this type of condition would have warranted care up to four months. The treating doctor did appear to follow the guidelines for Texas under the CQAPP, but there was never established a causal link between the ___ accident and the exacerbation to warrant treatment. Pain due to weather changes does not constitute an exacerbation.

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,