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

SOAH DOCKET NO. 453-05-4232.M5

MDR Tracking Number: M5-05-0104-01

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 09-03-04.

The IRO reviewed iontophoresis, therapeutic exercises, massage, ultrasound, electrical stimulation unattended, office visits and special reports rendered from 02-25-04 through 06-11-04 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 09-20-04, 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 97110 dates of service 03-08-04, 03-09-04, 03-11-04, 03-15-04, 03-18-04 denied with denial code S53 (supplemental payment) and dates of service 04-26-04 and 04-29-04 denied with denial code "N72" (not appropriately documented). 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 97033 dates of service 03-08-04, 03-09-04, 03-11-04, 03-16-04, and 03-18-04 denied with denial code "N2" (not appropriately documented). The requestor submitted documentation that supported delivery of services. Reimbursement is recommended per the Medicare Fee Schedule in the amount of 129.45 ($20.71 X 125% = $25.89 X 5 DOS).

CPT code 97018 date of service 03-18-04 denied with denial code "S"53" (supplemental payment). Per the EOB the recommended reimbursement of $8.30 per the Medical Fee Guideline effective 08-01-03 has been paid by the carrier. No additional reimbursement is recommended.

CPT code G0283 date of service 03-18-04 denied with denial code "S"53" (supplemental payment). Per the EOB the recommended reimbursement of $13.90 per the Medical Fee Guideline effective 08-01-03 has been paid by the carrier. No additional reimbursement is recommended.

CPT code 97033 dates of service 03-22-04 and 03-24-04 denied with denial code "D91" (duplicate bill). Since neither party submitted an original EOB this review will be per Rule 134.202. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of $51.78 ($20.71 X 125% = $25.89 X 2 DOS).

CPT code G0283 date of service 03-24-04 denied with denial code "D91" (duplicate bill). Since neither party submitted an original EOB this review will be per Rule 134.202. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of $13.90 ($11.12 X 125%).

Review of CPT code 97033 date of service 04-23-04 revealed that neither the requestor nor the respondent submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. Per Rule 133.307(e)(3)(B) the respondent did not submit an EOB as required. No reimbursement is recommended.

CPT code 97018 date of service 04-26-04 per the EOB dated 05-25-04 was paid in the amount of $8.30. Therefore no dispute exists.

CPT code G0283 date of service 04-26-04 per the EOB dated 05-25-04 was paid in the amount of $13.90. Therefore no dispute exists.

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 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 02-25-04 through 06-11-04 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 January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

October 7, 2004

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

Patient:
TWCC #:
MDR Tracking #: M5-05-0104-01
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

Reports from Dr. Payne, physical therapy notes and reports, reports from Dr. Stephen Dudas, MRI of the cervical spine and left shoulder, EMG/NCV study and two reports from designated doctor Jerome Kosoy, M.D.

CLINICAL HISTORY

This patient was employed as a security officer for the DISD. On ___ the patient attempted to break up a fight between two students and was thrown to the ground. She suffered injuries to her cervical and thoracic spine and left shoulder.

DISPUTED SERVICES

Under dispute is the medical necessity of iontophoresis, therapeutic exercises, massage ultrasound, electrical stimulation unattended, office visits and special reports.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The disputed services provided throughout the disputed dates of service (02/25/04 – 06/11/04) are found to be medically necessary and appropriate. Ms. ___ had a designated doctor examination twice, finding that the patient was improving as a result of the care provided. The carrier's own review agent also stated that this care would be appropriate in a pre-authorization letter.

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