

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Cotton D. Merritt, D.C. 2005 Broadway Lubbock, Texas 79401	MDR Tracking No.: M5-05-2478-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
06-28-04	08-13-04	99212-25	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
06-30-04	06-30-04	97032 and 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
07-01-04	07-01-04	97110 and 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
07-02-04	07-09-04	97110 and 1 unit of 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
07-12-04	07-12-04	97112 and 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
07-14-04	07-23-04	97110 and 1 unit 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
07-26-04	07-26-04	97110, 97112 and 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
07-28-04	07-28-04	97112 and 1 unit 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
08-02-04	08-02-04	97110 and 1 unit of 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
08-04-04	08-04-04	97110 and 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
08-06-04	08-11-04	97110 and 1 unit of 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
08-13-04	08-13-04	97110 and 1 unit of 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
07-02-04	08-13-04	97112 (all dos except those previously noted above)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor **did** prevail on the **majority** of disputed medical necessity issues. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$2,907.48**.

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 06-29-05, 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 codes 95851 and 95831 date of service 06-28-04 denied with denial code "G" (unbundling). Per the 2002 Medical Fee Guideline codes 95851 and 95831 are global to CPT code 99213 also billed on date of service 06-28-04. No reimbursement recommended.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute totaling \$2907.48 consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

_____	_____	08-17-05
Authorized Signature	_____	Date of Decision
Order by:	_____	_____
_____	_____	08-17-05
Authorized Signature	_____	Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Road, Irving, TX 75038

972.906.0603 972.255.9712 (fax)

Certificate # 5301

August 8, 2005

Revised: August 10, 2005

Revised: August 11, 2005

Revised: August 12, 2005

**ATTN: Program Administrator
Texas Workers Compensation Commission**

Medical Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100

Austin, TX 78744

Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-2478-01

RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 6.28.05.
- Faxed request for provider records made on 6.28.05.
- The case was assigned to a reviewer on 7.18.05.
- The reviewer rendered a determination on 8.4.05.
- The Notice of Determination was sent on 8.8.05.
- The Amended Notice of Determination was sent on 8.12.05.

The findings of the independent review are as follows:

Questions for Review

The procedures in question are electrical muscle stimulation (97032), Manual therapy technique (97140), Therapeutic exercise (97110), Office visit (99212-25) and neuromuscular re-education (97112). The dates of service in question are from 6.28.04 through the dates of 8.13.04. Mixed issues are listed as being involved for the denial. The date of injury is listed as of ____.

Determination

The PHMO, Inc. physician reviewer has also determined to **overturn the denial** on all the office visits (99212) from 6.28.04-8.13.04. Also **overturned** are the denials for the first Six (6) units of active and/or passive modalities (97032, 97140, 97110 and 97112) performed on each date of service. For example, if the carrier remitted payment on Three (3) units, the provider is entitled to an additional Three (3) units. Therefore, the approved visits are as follows:

6.29.04 - All charges

6.30.04 - All charges

7.01.04 - All charges

7.02.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)

7.06.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)

7.07.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)

7.09.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)

7.12.04 - All charges
7.14.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)
7.16.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)
7.19.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)
7.21.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)
7.22.04 - 97110, and 1 unit of 97140 (MAR of \$31.73)
7.23.04 - 97110, and 1 unit of 97140 (MAR of \$31.73)
7.26.04 - All charges
7.28.04 - 97112, and 1 unit of 97140 (MAR of \$31.73)
8.02.04 - 97110, and 1 unit of 97140 (MAR of \$31.73)
8.04.04 - All charges
8.06.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)
8.09.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)
8.11.04 - 99212-25, 97110, and 1 unit of 97140 (MAR of \$31.73)
8.13.04 - 97110, and 1 unit of 97140 (MAR of \$31.73)

PHMO, Inc. physician reviewer has determined to **uphold the denial** of all services not specifically approved hereinbefore. To assist MDR in processing this claim, these include all 97112 charges except for 7.12.04 & 7.26.04. They also include 1 unit of 97110 for most dates of service. The table of disputed services was organized by the number of procedures performed. Time units were not separately identified. Therefore, partial approval is awarded for some use of the 97140, since the reviewer allowed for 1 unit for most dates of service.

Summary of Clinical History

The patient was injured while working for . . . He was lifting a heavy piece of equipment when he felt a sharp pain in the lower back. The item was documented as weighing 60-80 pounds.

Clinical Rationale

The patient had lumbar spine surgical procedures performed in the lumbar spine at multiple levels at Shannon West Memorial Hospital. The surgery was done by a Robert LeGrand, MD. MRI studies demonstrated multiple levels of disc pathology. There were also NCV/EMG studies done by Cotton Merritt, DC.

Office visits are necessary for the rendering doctor. The number and frequency of these office visits are reasonable considering the severity of the patient's condition and the stage of care. This is for the purpose of being able to monitor the patient during the time in which the patient is receiving treatment from other practitioners or in house therapy. These are typically necessary until the patient is at MMI.

The enclosed records do indicate a reduction of the of the patient's perceived pain from an 8 to a 5 on the VAS scale. The observed ROM did improve as well while care was being rendered. Providers seeing the patient later in care seemed to indicate that the care offered did not produce lasting results. Dr. LeGrand specifically notes in his 1.10.05 report that the patient had not improved in the Seven months prior to his evaluation, a range which does cover the disputed care. Additionally, the care did not seem to improve the VAS score on the same visit, although there was a modest decline of the VAS over time.

On 6.28.04, the patient had pain on the VAS that was an 8. On this date, the patient had lumbar flexion that was 30 degrees and extension that was 10 degrees and the lateral flexion measurements were 10 and 15 degrees. Nine months later on 3.2.05 the patient had an 8 on the VAS indicating no long term change from conservative care in regards to perceived pain. As well as, the range of motion was actually worse with flexion that was listed as 15 degrees. This is only half of what it was initially on 6.28.04. Lumbar extension was also half at 5 degrees and the lateral flexion studies show 10 degrees in each direction.

There is a consensus from the providers that the patient had severe multilevel disc disease, which did result in surgical intervention. In light of this, 24 visits is medically appropriate, beginning with the visit on 6.28.2004. Although, there is a question as to the effectiveness of the care, the care did at least have the reasonable expectation of a beneficial outcome.

Moreover, the peer review provided by the carrier only covered the surgical procedure. It did not speak to the rehabilitation under dispute. Thus, the carrier's denial of these claims appears to be completely without foundation.

For each visit, a maximum of Six (6) units of passive and/or active procedures is generally regarded as appropriate. The formerly used TWCC:MFGs did allow for 2 hours of care, which I feel is a fairly liberal allowance. The WLDI's OGDs and ACEOMs guidelines on this, conversely, generally do not allow for a sufficient trial.

Clinical Criteria, Utilization Guidelines or other material referenced

- *Occupational Medicine Practice Guidelines*, Second Edition.
- *The Medical Disability Advisor*, Presley Reed MD
- *A Doctors Guide to Record Keeping*, Utilization Management and Review, Gregg Fisher
- Texas Workers Compensation Commission: *Medicine Fee Guidelines*, 1996
- Work Loss Data Institute, *Official Disability Guidelines*, 2004 edition
- *American College of Environmental and Occupational Medicine*, 2004 edition.

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals, P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department applicable to Commission Rule 102.5 this 8th day of August 2005. The Amended Notice of Determination was sent on the 12th day of August, 2005. The TWCC Medical Dispute Resolution department will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.

CC to be sent by TWCC:

Requestor

Respondent

Patient