

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 DC 2005 Broadway Lubbock TX 79401	MDR Tracking No.: M5-05-2531-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Rep Box # 54 Texas Mutual Insurance	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.: 99E 381618

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
7-8-04	7-8-04	97112 (1 unit) , 97140 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7-8-04	7-8-04	97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7-9-04	7-9-04	97110 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7-12-04	7-12-04	97110 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7-14-04	7-14-04	97110 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7-16-04	7-16-04	97110 (1 unit)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7-20-04	7-20-04	97110 (1 unit)	<input checked="" type="checkbox"/> Yes <input 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 **not** prevail on the majority of the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals \$238.33.

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 6-24-05 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.

Code 99212-25 billed for dates of service 7-9-04, 7-12-04, 7-14, 04, 7-16-04, and 7-20-04 was denied as MU, 12, TG – Physical therapy and rehab services may not be reported in conjunction with an E/M visit performed on the same day, provider billed for the service on the same day as a PT procedure, and documentation does not support the service billed. The requestor billed with modifier –25 to indicate a separate and significantly separate E/M service by same physical on day of procedure and the daily notes support level of service. Recommend reimbursement of \$44.16 x 5 days = \$220.80.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit \$459.13 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.

Ordered by:

Dee Z. Torres

8-16-05

Authorized Signature

Typed Name

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

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 en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-05-2531-01
NAME OF REQUESTOR: Cotton Merritt, D.C.
NAME OF PROVIDER: Cotton Merritt, D.C.
REVIEWED BY: Board Certified in Chiropractics
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 07/29/05

Dear Dr. Merritt:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for Texas Workers' Compensation Commission (TWCC) to randomly assign cases to IROs, TWCC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Chiropractics and is currently listed on the TWCC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An Employer's First Report of Injury or Illness dated ____
X-ray reports of the thoracic spine, cervical spine, and both wrists dated ____ and interpreted by Douglas Wright, M.D.
An evaluation at Lubbock Injury Rehabilitation by Christopher Myron, D.C. dated 06/24/04
An evaluation by Cotton Merritt, D.C. at Merritt Chiropractic, P.A. on 07/08/04
Treatment notes from Dr. Merritt on 07/09/04, 07/12/04, 07/14/04, 07/16/04, and 07/20/04
Requests for reconsiderations from Dr. Merritt regarding bills dated 07/08/04, 07/09/04, 07/12/04, 07/14/04/, 07/16/04, and 07/20/04
A letter "To Whom It May Concern" dated 06/27/05 from Dr. Merritt
A letter from Texas Mutual dated 07/08/05 from LaTreace Giles regarding the carrier's statement with respect to the dispute

Clinical History Summarized:

The Employer's First Report of Injury or Illness stated scaffolding moved and he sprained his back and wrist on _____. On _____, Dr. Myron diagnosed the claimant with a mild strain of the back and neck and a mild sprain of the right wrist. Dr. Merritt evaluated the claimant on 07/08/04 and diagnosed the claimant with lumbar intervertebral disc disorder without myelopathy secondary to a work related injury, a sprain/strain of the right wrist, and a sprain/strain of the right groin. Six to eight weeks of therapy were prescribed. From 07/09/04 through 07/20/04, the claimant attended therapy with Dr. Merritt and received neuromuscular reeducation, stretching,

gait training, and therapeutic exercises, as well as manual therapies. On 06/27/05, Dr. Merritt provided a letter "To Whom It May Concern" regarding the dispute over the dates of services from 07/08/04 through 07/20/04. Ms. Giles, from Texas Mutual, noted in her letter dated 07/08/05, the claimant received 30 units of 97110, 12 units of 97112, and 12 units of 97140. To date, the carrier had reimbursed eight units of 97110, five units of 97112, and five units of 97140. The carrier was also billed for two office visits on 07/08/04, of which reimbursement was made for 99204, but not 99212.

Disputed Services:

Therapeutic exercises, neuromuscular reeducation, and manual therapy techniques from 07/08/04 to 07/20/04

Decision:

I partly agree with the carrier's denial of the treatment provided by Dr. Merritt from 07/08/04 to 07/20/04. It would be reasonable for the claimant to have received 12 total units of 97110, 6 total units of 97112 and six total units of 97140 within the dates of service of 07/08/04 through 07/20/04.

Rationale/Basis for Decision:

Based upon review of the documentation, Dr. Merritt billed for treatment including a subsequent visit on 07/08/04, five units of therapeutic activities or exercises, two units of neuromuscular reeducation, and two units of manual therapy. On each of the other dates of services, including 07/09/04, 07/12/04, 07/14/04, 07/16/04, 07/20/04, Dr. Merritt billed for 99212-25, a subsequent visit, five units of exercise, two units of neuromuscular reeducation, and two units of manual therapy. Based upon the CMS Medicare guidelines for physical medicine, no more than 45 minutes of physical therapy should be provided in one office visit, in which 30 minutes would be therapeutic exercise without substantial documentation substantiating more treatment, which did not appear to be present. Therefore, based upon the documentation and CMS policy, reasonable and necessary treatment would include one office visit (99204) only, two units of therapeutic exercise (97110), one unit of neuromuscular reeducation (97112), and one unit of manual therapy (97140) on 07/08/04.

On the subsequent visits of 07/09/04, 07/12/04, 07/14/04, 07/16/04, and 07/20/04, reasonable treatment would include two units of therapeutic exercise, one unit of neuromuscular reeducation, and one unit of manual therapy only. Again, those are based upon CMS Medicare in regard to physical medicine. Based on the TWCC rules, 134.202 Medical Guidelines should be used as a reference for determination of treatment.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk **within twenty (20) calendar days** of your receipt of this decision (28 Texas Administrative Code 148.3).

This decision is deemed received by you **five (5) calendar days** after it was mailed and the first working day after the date this decision was placed in the carrier representative's box (28 Texas Administrative Code 102.5 (d)). A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to TWCC via facsimile or U.S. Postal Service on 08/03/05 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel