



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Cotton D. Merritt, D.C. 2005 Broadway Lubbock, Texas 79401	MDR Tracking No.: M5-05-2862
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Argonaut Southwest Insurance Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60, explanations of benefits, CMS 1500s and medical documentation
POSITION SUMMARY: "All care is reasonable and medically necessary" per the table of disputed services

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60 and explanations of benefits
POSITION SUMMARY: "As the Requestor has failed to establish the necessity for their excessive chiropractic treatments, as well as the irregular billing methods, no reimbursement is warranted".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
01-03-05 to 01-26-05	99212-25, 97110, 97112 and 97140	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
02-10-05	99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.89
02-11-05 to 03-30-05	99212-25	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
02-11-05, 02-14-05, 02-16-05 and 03-11-05 through 04-13-05	97110 (1 unit @ \$33.56 X 13 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$436.28
02-11-05, 02-14-05, 02-16-05 and 03-11-05 through 04-13-05	97112 (1 unit @ \$35.21 X 12 DOS))	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$422.52
02-11-05, 02-14-05, 02-16-05 and 03-11-05 through 04-13-05	97140 (1 unit @ \$31.79 X 12 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$381.48
02-11-05, 02-14-05, 02-16-05 and 03-11-05 through 04-13-05	97110 (more than 1 unit), 97112 (more than 1 unit) and (97140 more than 1 unit)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
02-15-05 and 03-16-05	97110, 97112 and 97140	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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 disputed medical necessity issues.

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 Medical Dispute Resolution.

On 07-26-05, 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 code 97110 (5 units) date of service 03-09-05 denied with denial code "W1" (Workers Compensation State Fee Schedule Adjustment). The carrier made a payment of \$67.12. The requestor submitted documentation per Rule 133.307(g)(3)(A-F) to support the service in dispute. Additional reimbursement is recommended in the amount of **\$100.68**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 134.202(c)(1), Rule 133.307(g)(3)(A-F)

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of \$1,369.29.

In addition, the Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Ordered by:

Authorized Signature

Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

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