



**Texas Department of Insurance, Division of Workers' Compensation**  
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity

#### PART I: GENERAL INFORMATION

|   |                                 |
|---|---------------------------------|
| <b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier |                                 |
| Requestor's Name and Address:   | MDR Tracking No.: M5-05-3065-01 |
| Cotton D. Merritt, D. C.<br>2005 Broadway<br>Lubbock, TX 79401                                | Claim No.:                      |
|   | Injured Employee's Name:        |
| Respondent's Name and Address:<br><br>TX Mutual Insurance Company, Box 54                     | Date of Injury:                 |
|   | Employer's Name:                |
|   | Insurance Carrier's No.:        |

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "All care is reasonable and medically necessary as related to the compensable injury."

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

| Date(s) of Service | CPT Code(s) or Description           | Medically Necessary?  | Additional Amount Due (if any) |
|--------------------|--------------------------------------|---|--------------------------------|
| 1-10-05 – 3-30-05  | CPT code 97110 (\$33.56 X 112 units) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$3758.72                      |
| 1-10-05 – 3-30-05  | CPT code 97140 (\$31.79 X 56 units)  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$1780.24                      |
| 1-10-05 – 3-30-05  | CPT code 99212-25 (\$45.26 X 6 DOS)  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$271.56                       |
| 1-10-05 – 3-30-05  | CPT code 97112 (\$35.21 X 12 units)  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$422.52                       |
|                    |                                      |   | \$6,233.04                     |

#### 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 prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$6,233.04.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1).

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to additional reimbursement in the amount of \$6,233.04. 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.

Findings and Decision by:

Donna Auby

1-24-06

Order by:

Margaret Ojeda

1-24-06

Authorized Signature

Typed Name

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.**

January 12, 2006  
August 30, 2005

Texas Workers Compensation Commission  
MS48  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744-1609

### **Amended NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-05-3065-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Cotton D. Merritt, DC**  
**Respondent: Texas Mutual Insurance Company**  
**MAXIMUS Case #: TW05-0175**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

### **Clinical History**

This case concerns a 47-year old male who sustained a work related injury on \_\_\_\_\_. The patient reported that while climbing on top of an oven, he twisted his lower back. He also reported feeling a sudden sharp pain with radiating pain to the right lower extremity. Diagnoses included lumbago, low back pain, lumbar strain/sprain, and lumbar intervertebral disc disorder without myelopathy. Treatment has included L5-S1 discectomy on 10/29/04.

### **Requested Services**

97110 – therapeutic exercises, 97140 – manual therapy technique, 99212-25 – office visits, and 97112 – neuromuscular reeducation from 1/10/05-3/30/05.

Documents and/or information used by the reviewer to reach a decision:

*Documents Submitted by Requestor:*

1. Merritt Chiropractic Records – 11/22/05-6/22/05
2. Shannon West Texas Memorial Discharge Summary – 5/5/05
3. Records from Robert H. LeGrand, Jr. MD – 3/17/05-5/26/05
4. Encounter Notes from Owen C. Dewitt, MD – 7/29/04-11/9/04

5. Covenant Health System Records – 10/29/04
6. UMC Emergency Center – 7/21/04
7. MRI Reports – 4/1/05, 7/23/04

*Documents Submitted by Respondent:*

1. None submitted

**Decision**

The Carrier's denial of authorization for the requested services is overturned.

**Rationale/Basis for Decision**

MAXIMUS CHDR chiropractor consultant indicated that according to the American College of Occupational and Environmental Medicine (ACOEM) 2005 Disability Guidelines and the National Spine Society's Phase III Clinical Guidelines for unremitting low back pain, the patient's post-operative rehabilitation all within the acceptable time frame after the microdiskectomy procedure. MAXIMUS CHDR chiropractor consultant noted the therapeutic exercise and manual therapy procedures are acceptable treatment interventions for this type of post-surgical rehabilitation. (Phase III Clinical Guidelines for Unremitting Low Back Pain, National Spine Society, 2002. American College of Occupational and Environmental Medicine (ACOEM), Disability Guidelines, Work Loss Data Institute, 2005.)

Therefore, the MAXIMUS physician consultant concluded that the 97110 – therapeutic exercises, 97140 – manual therapy technique, 99212-25 – office visits, and 97112 – neuromuscular reeducation from 1/10/05-3/30/05 were medically necessary for treatment of this patient's condition.

Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department