



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 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.: M5-06-1725-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Sentry Insurance Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "All care is reasonable and medically necessary as related to the compensable injury."

Principle Documentation:

1. DWC-60/Table of Disputed Services
2. CMS 1500
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "...If the NCV testing done in this case was a needle NCV/EMG, the chiropractor could not properly perform that procedure and is not entitled to reimbursement. If the NCV/EMG was a so-called "surface" NCV/EMG, it is the carrier's position that such testing has no diagnostic value and has not been shown to be reasonable or necessary in this case under CMS criteria."

Principle Documentation: Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-12-05	95903 (1 unit @ \$80.34 X 6 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$482.04
12-12-05	95904 (1 unit @ \$63.34 X 5 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$316.70
12-12-05	95936 (1 unit @ \$47.36 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$94.72
12-12-05	95861 (1 unit @ \$138.81 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$277.62
TOTAL			\$1,171.08

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 disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202)(c)(1)
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 reimbursement in the amount of \$1,171.08. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the Respondent 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.

Order by:

08-11-06

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.

NOTICE OF INDEPENDENT REVIEW DECISION

July 21, 2006

Program Administrator
Medical Review Division
Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #:
Injured Worker:
MDR Tracking #: M5-06-1725-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work related injury on ____ when he was involved in a vehicle rollover. This resulted in injury to his lower back, cervical spine, and left shoulder. The patient has received chiropractic care.

Requested Service(s)

(95904) Sensory nerve testing, each nerve, (95903) Nerve conduction test – with F wave, (95936) H-reflex test, and (95861) Needle electromyography on 12/12/05

Decision

It is determined that the (95904) Sensory nerve testing, each nerve, (95903) Nerve conduction test – with F wave, (95936) H-reflex test, and (95861) Needle electromyography on 12/12/05 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that the patient was seen 2 days after the injury by a "company doctor" who prescribed medications and rendered trigger point injections: when these were proven ineffective, physical therapy was then attempted. The treating doctor's office notes indicated that on the date of service 12/05/05, the patient was "c/o numbness in fingers now", and "sensory-motor loss in 4th and 5th fingers, buttocks" with response to therapy indicated as "unchanged". In the "labs & x-rays" section of the office note for that same date of service, the doctor had circled "NCV", and the completed a return to work slip that indicated his return "pending MRI and NCV". The company doctor's referral orthopedist made reference to both an EMG/NCV being necessary in his report of 12/01/05.

When the patient changed treating doctors to a doctor of chiropractic on 12/09/05, it was the chiropractor's professional opinion – based on the patient's presentation, the history he took and the examination he performed – that the electro-diagnostic tests in dispute in this case were medically necessary. The medical records submitted supported this procedure as medically necessary. In addition, this position is further supported by the former doctors who arrived at the same conclusion.

This decision by the IRO is deemed to be a DWC decision and order.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code 413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment