



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity

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, TX 79401

MDR Tracking No.: M5-06-1726-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

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

Position summary states, "All care is reasonable and medically necessary as related to the compensable injury."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. EOB's

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) |
|--------------------|-------------------------------|---|--------------------------------|
| 9-16-05 – 11-2-05 | 99212-25 (\$45.26 x 14 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$633.64 |
| 9-16-05 – 11-2-05 | 97035 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$14.63 |
| 9-16-05 – 11-2-05 | 97032 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$19.00 |
| 9-16-05 – 11-2-05 | 97140-59 (\$31.79 x 13 units) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$413.27 |
| | Grand total | | \$1080.54 |

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. The amount due the requestor for the items denied for medical necessity is \$1080.54.

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 \$1080.54. 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 and Order by:

Medical Dispute Officer

7-28-06

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

| | |
|--|-----------------------|
| TDI-WC Case Number: | |
| MDR Tracking Number: | M5-06-1726-01 |
| Name of Patient: | |
| Name of URA/Payer: | Cotton D. Merritt, DC |
| Name of Provider: (ER, Hospital, or Other Facility) | |
| Name of Physician: (Treating or Requesting) | Cotton D. Merritt, DC |

July 11, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

DOCUMENTS REVIEWED

Available documentation received and included for review consists of initial and subsequent reports and treatment records from Dr. Merritt (DC), including electrodiagnostic testing and functional capacity evaluations; Designated doctor reports from Dr. Hill, (MD); Operative report, Dr. Dabezies.

CLINICAL HISTORY

Mr. _____ a 39-year-old male, sustained a crush injury to his right hand with multiple fractures and open wound on _____. He was working in a cotton gin when his hand was caught in the lid. He underwent emergency surgery which included pending to stabilize multiple comminuted displaced fractures of the mid and distal phalanges of the third to fifth digits. He underwent a second surgery on 8/19/05. He then undertook post surgical rehabilitation with Dr. Merritt, which included combination of exercises with supportive and adjunctive edge of therapeutic modalities and manual therapy. Electrodiagnostic undertaken on 11/8/05 was unremarkable. The patient returned to work in December 2006.

A designated doctor's appointment on 5/27/05 determined the patient was not at maximum medical improvement, requiring further rehabilitation. Subsequently he was found to be at MMI on 1/24/06 with a 25% whole person impairment.

REQUESTED SERVICE(S)

Physical therapy services: 97032 (electrical stimulation), 97035 (ultrasound), 97140-59 (manual therapy). 99212-25 office visits; 9/16/05-11/2/05.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

The records demonstrate that the patient improved with care. The employment of manual therapy and adjunctive therapeutic modalities in conjunction with components of an active treatment platform were appropriate, especially in dealing with the complexities of a post surgical crush injury.

Good improvement was noted by Dr. Merritt with the therapy, established goals were met with improvement in both range motion and grip strength. The patient returned to work following the completion of the program.

References:

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

The Work Loss Data Institute's *Official Disability Guidelines, third edition 2005*

The American College of Occupational and Environmental Medicines *Occupational Medicine Practice Guidelines*,

The American Physical Therapy Association *Guidelines for Programs for Injured Worker's*, 1995

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and 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.

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell