



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: David Rabbani, D.C. 7447 Harwin Suite 180 Houston, Texas 77036	MDR Tracking No.: M5-06-0315-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DWC package. Position summary: Per table of disputed services "documented and necessary".

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

Response to DWC package. Position summary: These charges are denied as not medically necessary according to the recommendation of a peer review.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
01-05-05 to 01-07-05	97545-WH-CA and 97546-WH-CA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,344.00

#### 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 **prevailed** on the disputed medical necessity issues.

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

28 Texas Administrative Code Sec. 133.308 and 134.202

**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 reimbursement in the amount of \$1,344.00. 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 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:

12-06-05

\_\_\_\_\_  
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.**



CompPartners Peer Review Network  
Physician Review Recommendation  
Prepared for TDI/DWC

**Claimant Name:** \_\_\_\_\_  
**Texas IRO # :** \_\_\_\_\_  
**MDR #:** M5-06-0315-01  
**Social Security #:** \_\_\_\_\_  
**Treating Provider:** David Rabbani, D.C.  
**Review:** Chart  
**State:** TX

**Review Data:**

- Notification of IRO Assignment dated 10/19/05, 1 page.
- Receipt of Request dated 10/19/05, 1 page.
- Medical Dispute Resolution Request dated 4/15/05, 1 page.
- Provider Federal Tax Identification Number and the License/Certification/Registration Number Request Forms, 4 pages.
- Table of Disputed Services, dated 1/5/05 through 1/7/05, 1 page.
- Explanation of Payment dated 3/22/05, 1 page.
- Notice of Transfer of Claim to Another Field Office dated 9/27/04, 1 page.
- Notice of New Texas Worker's Compensation Commission Number dated 4/19/04, 1 page.
- Employer's Report For Reimbursement of Voluntary Payment dated 4/2/04, 1 page.
- Request and Agreement for Worker's Compensation Wage Supplementation Payments dated 4/5/04, 1 page.
- Fax Cover Sheet dated 4/8/04, 1 page.
- Work Status and Restriction Form dated 4/6/04, 1 page.
- Summary of Transpired Events dated 11/7/05, 3 pages.
- Order for Payment of Independent Review Organization Fee dated 11/1/05, 1 page.
- Official Notification of Scheduled Examination Appointment dated 4/18/05, 2 pages.
- Texas Worker's Compensation Commission Advisory 2003-15, Subject: Emergency and Immediate Post-Injury Medical Care, 1 page.
- Letter dated 10/21/05, 1 page.
- Physician's Orders dated 3/30/04, 1 page.
- Emergency Physician Record dated 3/30/04, 1 page.
- Emergency Nursing Record dated 3/30/04, 3 pages.
- Discharge Summary/Instructions dated 3/30/04, 3 pages.
- Emergency Room Service Face Sheet dated 3/30/04, 1 page.
- Medical Records Authorization Release Form dated 4/1/04, 1 page.
- Daily Patient's Record dated 4/5/04, 4/7/04, 2 pages.
- Consultation and Treatment Report dated 4/5/04, 3 pages.
- Texas Worker's Compensation Work Status Report dated 4/8/04, 1 page.
- Daily Patient's Record dated 4/9/04, 4/10/04, 4/12/04, 4/14/04, 4/16/04, 4/19/04, 4/21/04, 4/23/04, 4/26/04, 4/28/04, 10 pages.
- Re-evaluation Report dated 4/30/04, 2 pages.
- Daily Patient's Record dated 4/30/04, 1 page.
- Texas Worker's Compensation Work Status Report dated 5/3/04, 1 page.
- Daily Patient's Record dated 5/3/04, 1 page.
- Fax Cover Sheet dated 5/5/04, 5/3/04 2 pages.
- Daily Patient's Record dated 5/5/04, 5/7/04, 5/12/04, 5/17/04, 5/19/04, 5/21/04, 5/24/04, 5/26/04, 5/14/05, 9 pages.

- Return-to-Work Referral Form dated 5/6/04, 1 page.
- Re-evaluation Report dated 5/26/04, 2 pages.
- Texas Worker's Compensation Work Status Report dated 5/28/04, 1 page.
- Fax Cover Sheet dated 5/28/04, 1 page.
- Cervical Spine Radiology Report dated 4/5/04, 1 page.
- Daily Patient's Record dated 6/14/04, 1 page.
- Re-evaluation Report dated 6/14/04, 2 pages.
- Texas Worker's Compensation Work Status Report dated 6/14/04, 1 page.
- Cervical Spine MRI Report dated 6/18/04, 1 page.
- Thoracic Spine MRI Report dated 6/18/04, 1 page.
- Letter dated 6/28/04, 1 page.
- History and Physical Report dated 7/9/04, 3 pages.
- Letter dated 7/12/04, 1 page.
- Texas Worker's Compensation Work Status Report dated 7/14/04, 1 page.
- Operative Note dated 7/27/04, 2 pages.
- Re-evaluation Report dated 8/2/04, 2 pages.
- Daily Patient's Record dated 8/4/04, 8/6/04, 8/9/04, 3 pages.
- Progress Note dated 8/10/04, 1 page.
- Daily Patient's Record dated 8/11/04, 8/13/04, 8/16/04, 8/18/04, 4 pages.
- Letter dated 8/20/04, 1 page.
- Daily Patient's Record dated 8/20/04, 8/23/04, 2 pages.
- Anesthesia Record dated 8/25/04, 1 page.
- Operative Note dated 8/25/04, 2 pages.
- Re-evaluation Report dated 8/27/04, 2 pages.
- Daily Patient's Record dated 8/27/04, 9/1/04, 9/3/04, 9/10/04, 9/13/04, 9/17/04, 9/15/04, 9/20/04, 9/22/04, 9 pages.
- Progress Note dated 9/24/04, 1 page.
- Required Medical Examination Notice or Request for Order dated 9/10/04, 1 page.
- Appointment Confirmation Letter dated 10/1/04, 1 page.
- Re-evaluation Report dated 10/6/04, 2 pages.
- Daily Patient's Record dated 10/6/04, 1 page.
- Texas Worker's Compensation Work Status Report dated 10/11/04, 1 page.
- Required Medical Examination Report dated 10/11/04, 6 pages.
- Letter dated 10/19/04, 3 pages.
- History and Physical Report dated 10/21/04, 2 pages.
- Letter dated 11/5/04, 1 page.
- Bone Scan Report dated 11/30/04, 1 page.
- Cervical Spine CT Scan Report dated 11/30/04, 2 pages.
- Clinic Follow-up Report dated 12/6/04, 1 page.
- Correspondence dated 12/6/04, 1 page.
- Functional Capacity Evaluation Report dated 12/21/04, 3 pages.
- Functional Capacity Evaluation and Narrative Report dated 12/21/04, 23 pages.
- Acurom Inclinometry Report dated 12/21/04, 10 pages.
- Texas Worker's Compensation Work Status Report dated 12/22/04, 1 page.
- Progress Update dated 12/22/04, 1 page.
- Weekly Conference Report dated 12/30/04, 1/7/03, 1/13/05, 1/20/05, 15 pages.
- Daily Patient's Record dated 9/8/04, 1 page.
- Vocational Assessment Report dated 1/20/05, 2 pages.
- Re-evaluation Report dated 1/31/05, 2 pages.
- Initial Office Visit Report dated 2/11/05, 4 pages.
- Preliminary Work Hardening Review dated 2/22/05, 3 pages.
- Re-evaluation Report dated 2/23/05, 2 pages.
- Daily Patient's Record dated 2/23/05, 1 page.
- Request for Designated Doctor dated 4/11/05, 1 page.

- Injury and Treatment Information dated 4/1/05, 1 page.
- Office Visit and Treatment Plan Report dated 4/5/04, 3 pages.
- History and Physical Report dated 4/22/05, 3 pages.
- Letter dated 4/27/05, 4 pages.
- Report (only page 2; unspecified date), 1 page.
- Request for Taxpayer Identification Number and Certification dated 6/21/04, 1 page.
- Anesthesia Record dated 7/27/04, 1 page.
- Medical Statement dated 7/27/04, 1 page.

**Reason for Assignment by TDI/DWC:** Determine the medical necessity of the previously denied work hardening program for dates of service of 1/5/05 through 1/7/05.

**Determination:** REVERSED - previously denied work hardening program for dates of service of 1/5/05 through 1/7/05.

**Rationale:**

**Patient's age:**

**Gender:**

**Date of Injury:** \_\_\_\_

**Mechanism of Injury:** Fell from a pole, injuring his head and spine.

**Diagnoses:** Cervical disk herniation, rotator cuff sprain/strain.

While employed for \_\_\_\_\_, the claimant was climbing a pole. The claimant was approximately 6 ft. above the ground when he lost his grip, causing him to fall backwards. The claimant landed on the back of his head and struck a steel railing that was lying on the ground. The claimant had a loss of consciousness and was taken to West Houston Medical Center for treatment. On 4/1/2004, the claimant presented to the office of Dr. Rabbani, D.C., complaining of head and neck pain. The claimant underwent a course of conservative manual medicine that resulted in significant improvement. On 5/26/2004, the claimant was evaluated and found to be asymptomatic with no significant objective findings. The claimant was returned to work without restrictions. On 6/14/2004, the claimant returned to the provider's office following a deterioration of his condition which resulted in an increase in cervical complaints. An MRI of the cervical spine revealed a focal posterior central subligamentous herniation at C4-5 measuring 3 mm, compressing the thecal sac, without spinal cord or nerve root compression. There was also a compression fracture deformity of the superior endplate of C5 with associated anterolateral spondylosis. Based on these findings, the claimant was referred to Dr. Uday Doctor for an evaluation. A recommendation for an epidural steroid injection was submitted. On 7/27/2004, the claimant received an epidural steroid injection (ESI) that revealed mild benefit. A subsequent ESI was performed on 8/25/2004 that did not provide any significant or long lasting improvement. Dr. Doctor re-evaluated the claimant and indicated that the claimant undergo a surgical consultation. On 10/21/2004, the claimant was evaluated by Dr. Fitzgerald, a neurologist, who recommended a bone scan and CT scan of the cervical spine. The 11/30/2004 bone scan and CT scan proved to be normal. Dr. Fitzgerald recommended that the claimant begin a return to work program. On 12/21/2004, the claimant underwent a functional capacity evaluation that revealed the claimant was unable to participate at his job required physical demand capacity. On 12/27/2004, the claimant began a work hardening program. The claimant completed four weeks of work hardening. A peer review was performed on 2/22/2005 that indicated that only two weeks of work hardening was appropriate. The purpose of this review is to determine if the work hardening for dates of service 1/5/2005 through 1/7/2005 were appropriate. The medical necessity for the work hardening for dates of service 1/5/2005 to 1/7/2005 was established. The claimant underwent a functional capacity evaluation that determined that the claimant was unable to function at his normal physical demand level. On 12/27/2004, the claimant began a work hardening program. Week two dates of service were 1/3/2005 through 1/7/2005. Week 3 dates of service 1/10/2005 to 1/14/2005 and week 4 for dates of service 1/17/2005 to 1/21/2005. A comparison between the week one weekly conference report and the week two weekly conference report, revealed improvement in the claimant's material handling, indicating an increase in strength. This clearly indicated that the claimant benefited from week two of work hardening for dates of service 1/3/2005 through 1/7/2005. The week three weekly conference report, revealed additional improvement in material handling, indicating that the claimant benefited from weeks 1 through 3. It was clear from the submitted documentation that this claimant responded to the work hardening program initially. It was noted that following week four of the program, the claimant's condition had plateaued and then he was no longer making improvement. At that time, the work hardening program was appropriately terminated.

**Criteria/Guidelines utilized:** TWCC rules and regulations.

ACOEM Guidelines, 2<sup>nd</sup> Edition, Chapters 6 and 8.

*Physical Medicine & Rehabilitation, Second Edition*, by Randall L. Braddom, Saunders 2000, Chapter 45.

**Physician Reviewers Specialty:** Chiropractic

**Physician Reviewers Qualifications:** Texas licensed DC, and is also currently listed on the TWCC ADL list.

**CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that 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 the decision before the referral to CompPartners, Inc.**

### 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.