



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: Rehab 2112 P O BOX 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M5-06-1138-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: DWC-60 package
POSITION SUMMARY: "Services were medically necessary"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: Response to DWC-60 package
POSITION SUMMARY: "After review of this request, no additional payment was recommended towards the amount in dispute".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-29-05 to 07-20-05	97545-WH-CA and 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
07-26-05	97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$296.00

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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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 \$296.00. 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:

03-31-06

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.

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:	M5-06-1138-01
Name of Patient:	
Name of URA/Payer:	Rehab 2112
Name of Provider: (ER, Hospital, or Other Facility)	Rehab 2112
Name of Physician: (Treating or Requesting)	Inson Stoltz, DC

March 29, 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

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence, examination and treatment records from the provider
2. Rehab 2112 Work Hardening Treatment Notes
3. Psychology Group Notes
4. Carrier Reviews
5. Carrier EOBs
6. Initial, Interim and Final FCE reports
7. Lumbar MRI Report
8. X-ray Report
9. NCV/EMG Reports
10. Video Surveillance Report
11. Report from Charles W. Kennedy, Jr., M.D.
12. Reports from Marlon D. Padilla, M.D.
13. Reports from Arthur J. Speece, III, D.O.
14. ESI Operative Reports

The claimant underwent diagnostic imaging, physical medicine treatments, ESIs and work hardening after injuring his lumbar spine at work on ____ when he pulled on 10-13 carts tethered together with a rope.

REQUESTED SERVICE(S)

Work hardening program and 97750-FC FCE from 06/29/05 through 07/26/05.

DECISION

The 07/26/05 final FCE is approved.

The work hardening program is denied.

RATIONALE/BASIS FOR DECISION

In the preamble of the Texas Workers Compensation Commission's amendments to rule 134.600, the Commission states as follows: "Over-utilization of medical care can both endanger the health of injured workers and unnecessarily inflate system costs. Unnecessary and inappropriate health care does not benefit the injured employee or the workers' compensation system. Unnecessary treatment may place the injured worker at medical risk, cause loss of income, and may lead to a disability mindset. Unnecessary or inappropriate treatment can cause an acute or chronic condition to develop." 1 In its report to the legislature, the Research and Oversight Council on Texas Workers' Compensation explained its higher costs compared to other health care delivery systems by stating, "Additional differences between Texas workers' compensation and Texas group health systems also widen the cost gap. These differences include...in the case of workers' compensation, the inclusion of costly and questionable medical services (e.g., work hardening/conditioning.)" 2 In this case, the provider's work hardening program is just the type of questionable services of which the TWCC and the legislature spoke when expressing concern in regard to medically unnecessary treatments that may place the injured worker at medical risk, create disability mindset, and unnecessarily inflate system costs.

Current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises. There is also no strong evidence for the effectiveness of multidisciplinary rehabilitation as compared to usual care." 3 The literature further states "...that there appears to be little

1 26 Tex. Reg. 9874 (2001)

2 "Striking the Balance: An Analysis of the Cost and Quality of Medical Care in Texas Workers' Compensation System," Research and Oversight Council on Workers' Compensation, Report to the 77th Legislature, page 6.

3 Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.

scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities..." 4 And a systematic review of the literature for a multidisciplinary approach to chronic pain found only 2 controlled trials of approximately 100 patients with no difference found at 12-month and 24-month follow-up when multidisciplinary team approach was compared with traditional care.5 Based on those studies, the medical necessity of the disputed treatment is not supported.

And finally, the records fail to substantiate that the disputed services fulfilled statutory requirements 6 for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment. While the provider (page 4 of his 02/09/06 MDR request) stated that the 07/26/05 final FCE showed lumbar ranges of motion and bilateral SLR to be within normal limits, it is important to note that bilateral SLR, left lateral flexion and right lateral flexion were already within normal limits prior to the initiation of the disputed treatment on 06/24/05. Moreover, the patient's pain rating was 5/10 on 06/28/05 prior to the initiation of the disputed treatment, was 5/10 on most every visit, and remained at 5/10 on 07/20/05 at the termination of the disputed treatment.

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: _____

4 Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults. Cochrane Database Syst Rev. 2003;(2):CD002194.

5 Karjalainen K, et al. Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults. Cochrane Database of Systematic Reviews 2000;2.

6 Texas Labor Code 408.021

Printed Name of IRO Employee: Cindy Mitchell