



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**

**Type of Requestor:** ( X ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:  South Coast Spine and Rehab, P. A. 620 Paredes Line Road Brownsville, TX 78521	MDR Tracking No.: M5-06-1314-01
	Previous Tracking No.: M4-05-3959-01
	Claim No.:
Respondent's Name and Address:  TX Workers Compensation Sol, Box 19	Injured Employee's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Position Summary: "We are officially notifying Medical Review Division (the Division) that South Coast Spine and Rehabilitation, P. A. (the Requestor) and TPS Edwards Claims Administration were unable to agree on the issues that fall under the jurisdiction of the "Medical Review Division". Therefore, South Coast Spine and Rehabilitation, P.A. is requesting a "Medical Dispute Resolution" of a medical fee dispute pursuant to 133.307(a-f)..."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOBs

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

Position Summary: "...Carrier concedes that the doctor rendering treatment, E. Ray Strong, DC was on the Approved Doctor List (ADL) at the time that services were provided. However, Carrier stands on initial dispute of 11-3-04 disputing treatment for "V"-unnecessary Treatment with Peer Review..."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. Peer review

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

<u>Date(s) of Service</u>	<u>CPT Code(s) or Description</u>	<u>Medically Necessary?</u>	<u>Additional Amount Due (if any)</u>
9-22-04 – 10-05-04	97124, 97113, 97035, 99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

**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 disputed medical necessity issues.

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

Texas Labor Code 413.011(a-d) and 413.03  
28 Texas Administrative Code Sec,134.1, 133.308

**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 Division has determined that the Requestor is not entitled to reimbursement of the IRO fee and is not entitled to reimbursement for the services involved in this dispute.

**Findings and Decision by:**

**Medical Dispute Officer**

9-08-06

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date of Findings and Decision

**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.**

# ZRC MEDICAL RESOLUTIONS

August 31, 2006

Re: MDR #: M5 06 1314 01 Injured Employee: \_\_\_  
DWC #: \_\_\_ DOI: \_\_\_  
IRO Cert. #: 5340 SS#: \_\_\_

**TRANSMITTED VIA FAX TO:**

**TDI, Division of Workers' Compensation**

Attention:

Medical Dispute Resolution

Fax: (512) 804-4868

**RESPONDENT: Edwards Claims**

**TREATING DOCTOR: Robert Howell, DC**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to ZRC Medical Resolutions for an independent review. ZRC has performed an independent review of the medical records to determine medical necessity. In performing this review, ZRC reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the president of ZRC Medical Resolutions, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a Doctor of Chiropractic as well as a Doctor of Osteopathy, is board certified in physical medicine and rehabilitation and is currently listed on the DWC Approved Doctor List.

This decision by ZRC Medical Resolutions, Inc. 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, 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.

Sincerely,  
Jeff Cunningham, DC  
President



**REVIEWER'S REPORT**  
**M5 06 1314 01**

**Information Provided for Review:**

1. Records from South Coast Spine and Rehab Center, P.A.
2. First Rio Valley Medical, P.A.
3. Record review from Dr. Smith 02/11/03
4. Record review from Dr. Crane 08/03/03
5. Independent Medical Evaluation by orthopedic surgeon Dr. Kennedy 06/07/02
6. Re-examination with orthopedic surgeon Dr. Kennedy on 05/19/04
7. Office notes from Dr. Kramer including procedure notes for lumbar facets and sacroiliac injections
8. Billing documentation for services provided by Dr. Howell, chiropractor
9. MRI scan reports of the lumbar spine from 09/09/01, 09/30/02 and 09/23/04

**Clinical History:**

The patient is a 61-year-old male who, on the date of his \_\_\_ injury, reportedly slipped and fell at work for the \_\_\_\_\_ where he worked full time as a custodian. Following this, he complained of cervicothoracic lumbar pain as well as right shoulder, right elbow, and right wrist pain.

**Disputed Services:**

Massage therapy (97124), aquatic therapy (97113), ultrasound (97035), and office visits (99213). The date of services in dispute are 09/22/04 through 10/04/04 for services provided by South Coast Spine and Rehab.

**Decision:**

I AGREE WITH THE DETERMINATION MADE BY INSURANCE CARRIER IN THIS CASE.

**Rationale:**

It is my opinion that the massage therapies, aquatic therapy, and ultrasound therapy provided from 09/22/04 through 10/05/04 were not medically indicated. It is my opinion that this patient had undergone extensive therapeutic intervention prior to the dates of

service including extensive chiropractic care as well as injection therapy. By review of the 3 MRI scans, he has degenerative changes in the lumbar spine, which actually as of 09/23/04 showed no herniation. Management of the symptomatology associated with the degenerative disc disease is a home exercise program as recommended by the Independent Medical Examination by Dr. Kennedy. The office visits associated with the attendant care from 09/22/04 through 10/05/04 provided by South Coast Spine and Rehab would therefore also not be supported as being medically necessary in my opinion. This gentleman may have required chiropractic management including massage, aquatic and ultrasound therapies initially after he fell, but there is no indication that for the time frame noted above (09/22/04 through 10/05/04) that these services were indicated or necessary relative to the original work incident of \_\_\_\_.

**Screening Criteria/Literature:**

In my professional experience utilizing the 3 MRI scan reports, the 2 Independent Medical Evaluations, the progress notes from South Coast Spine Rehab Center indicating very little objective evidence of improvement during the treatment provided from 09/22/04 through 10/05/04, the treatment rendered was not medically necessary relative to the \_\_\_\_ work incident.