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: Dr. Tommy Overman/Russell Blaylock, OTR 6161 Harry Hines Blvd Ste # 105 Dallas, Texas 75235	MDR Tracking No.: M5-06-1433-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Harris & Harris Rep box 42	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package
POSITION SUMMARY: Per the table of disputed services "necessary treatment".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: None submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07-25-05 to 08-25-05	90889, 90801, 97545-WH-CA, 97546-WH-CA and 97750-FC	☐ Yes ☒ 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

28 Texas Administrative Code Sec. 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 additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Authorized Signature	Typed Name	05-17-06 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.

CompPartners Final Report

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

Claimant Name: ___
Texas IRO # : ___
MDR #: M5-06-1433-01
Social Security #: ___
Treating Provider: James Cable, MD
Review: Chart
State: TX
Date Completed: 5/15/06

Review Data:

- **Notification of IRO Assignment dated 4/19/06, 1 page.**
- **Receipt of Request dated 4/19/06, 1 page.**
- **Medical Dispute Resolution Request/Response dated 4/3/06, 1 page.**
- **List of Treating Providers (date unspecified), 1 page.**
- **Table of Disputed Services dated 8/25/05, 8/24/05, 8/23/05, 8/18/05, 8/17/05, 8/16/05, 8/4/05, 8/3/05, 8/2/05, 8/1/05, 7/28/05, 7/27/05, 7/26/05, 7/25/05, 2 pages.**
- **Explanation of Benefits dated 8/25/05, 8/24/05, 8/23/05, 8/18/05, 8/17/05, 8/16/05, 8/4/05, 8/3/05, 8/2/05, 8/1/05, 7/28/05, 7/27/05, 7/26/05, 7/25/05, 6 pages.**
- **Reconsideration Request dated 9/27/05, 2 pages.**
- **Health Insurance Claim Form dated 8/4/05, 8/3/05, 8/2/05, 8/1/05, 7/28/05, 7/27/05, 7/26/05, 7/25/05, 4 pages.**
- **Work Hardening Weekly Summary dated 8/26/05, 8/19/05, 8/5/05, 7/29/05, 12 pages.**
- **SOAP Notes dated 8/23/05, 8/18/05, 8/16/05, 8/3/05, 8/1/05, 7/28/05, 5 pages.**
- **Work Hardening Daily Progress Note dated 8/25/05, 8/24/05, 8/23/05, 8/18/05, 8/17/05, 8/16/05, 8/4/05, 8/3/05, 8/2/05, 8/1/05, 7/29/05, 7/27/05, 7/26/05, 12 pages.**
- **Fax Confirmation Sheets dated 9/30/05, 2 pages.**

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for:

1. Preparation of report of patient's psychiatric status, history, treatment or progress (other than for legal or consultative purposes) for other physicians, agencies or insurance carriers (90889).
2. Psychiatric diagnostic interview examination (90801).
3. Work hardening (97545-WH-CA).
4. Work hardening each additional hour (97546-WH-CA).
5. Functional capacity examination (97750-FC).

Dates of service: 7/25/05 through 8/25/05

Determination: UPHELD - the previously denied request for:

1. Preparation of report of patient's psychiatric status, history, treatment or progress (other than for legal or consultative purposes) for other physicians, agencies or insurance carriers (90889).
2. Psychiatric diagnostic interview examination (90801).
3. Work hardening (97545-WH-CA).
4. Work hardening each additional hour (97546-WH-CA).
5. Functional capacity examination (97750-FC).

Dates of service: 7/25/05 through 8/25/05

Rationale:

Patient's age:
Gender:
Date of Injury: ___
Mechanism of Injury: Not stated for this review.
Diagnoses: Cervical, lumbar and thoracic pain.

The patient is a 48-year-old female who sustained an injury to the cervical, thoracic, and low back. Of note, due to the lack of earlier treatment records involving clinical examinations and diagnostic testing, this review was extremely limited. From the report of September 27, 2005, the claimant had been working light duty, secondary to the Functional Capacity Evaluation (FCE) which revealed a light ADL level. The requesting provider stated that the patient needed to progress to a higher functional level in order to return to work fulltime. She was then placed in a work hardening program on July 25, 2005, which accomplished the goal of returning this claimant to work fulltime, and full duty. Of note, the data submitted for review did not include documentation such as an evaluation by a mental healthcare practitioner or psychosocial testing for example; Beck's Anxiety Inventory (BAI), Beck's Depression Inventory (BDI), or Global Functioning Assessment (GFA), which would help to support attending a work hardening program. The data submitted for review included no comprehensive multidisciplinary examination and evaluation. With the absence of documentation of such an examination and evaluation, the medical necessity for requested work hardening cannot be considered. Work hardening programs are interdisciplinary in nature with a goal of addressing the functional, physical, behavioral, and vocational needs of the injured worker. Without the proper documentations of psychosocial issues, the claimant was probably more suited for entrance criteria for a work conditioning program.

Insofar as the request for a quantitative Functional Capacity Evaluation (FCE) is concerned, the data submitted for review failed to provide any prior such evaluations. Furthermore, the ACOEM Guidelines set out that Functional Capacity Evaluations can be deliberately simplified, based upon multiple assumptions and subjective factors, which are not always apparent to the requesting provider. There was little scientific evidence confirming that functional capacity evaluations predict an individual's actual capacity to perform in the workplace. Hence with any behavior, an individual's performance on FCE is probably influenced by multiple non-medical factors other than physical impairments. Based on the data provided, the requested functional capacity evaluation (FCE) cannot be recommended.

Pertaining to the psychiatric diagnostic interview examination and preparation of reports of the patient's psychiatric status, history, treatment, or progress cannot be certified due to the lack of data submitted for review failing to provide any detail of this patient's psychosocial issues relating to the chronic pain behavior.

Criteria/Guidelines utilized: TDI/DWC Rules and Regulations.
1. ACOEM Guidelines, 2nd Edition, Chapters 6, 7, 8, and 12.
2. Clinical Orthopedic Rehabilitation, 2nd Edition, edited by S. B. Brotzman, M.D.
3. American Physical Therapy Association Guidelines for Work Conditioning/Work Hardening.

Physician Reviewers Specialty: Pain Management

Physician Reviewers Qualifications: Texas Licensed M.D. and is also currently listed on the TDI/DWC 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.

American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition. Chapter 6, Chronic pain, Pg 116-117

Summary

Physicians should acknowledge the patient's experience of pain. Pain can be independent of the degree of physical pathology. The pain experience is modified by coping mechanisms; cultural and personal expectations; the patient's current psychological state; tissue damage and repair; and the influences, expectations, and responses of health care providers. It is critical for physicians to convey acceptance of, and empathy with, information the patient shares. Anomalous or exaggerated expressions of pain indicate that medical and psychological evaluations may be warranted.

Pain management focuses on functional restoration. Because return to function is essential to a return to health, occupational health professionals are concerned with return to function. It is very important to identify, at as early a point as possible, the development of chronic pain patterns and responses. Maintaining function will minimize the stiffness, aches, and atrophy that result from being sedentary. Typically, when function improves, so does perceived pain.

American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition. Chapter 8-Neck and upper back, Pg 173-175

Initial Care

Comfort is often a patient's first concern. Nonprescription analgesics will provide sufficient pain relief for most patients with acute and subacute symptoms. If treatment response is inadequate (i.e., if symptoms and activity limitations continue), prescribed pharmaceuticals or physical methods can be added. Comorbid conditions, side effects, cost, and provider and patient preferences generally guide the clinician's choice of recommendations. Table 8-5 summarizes comfort options.

• Manipulation has been compared to various treatments, but not placebo or nontreatment, for patients with neck pain in nearly twenty randomized clinical trials. More than half favored manipulation, with one reporting better results in combination with exercise, while the remainder indicated treatments were equivocal. Cervical manipulation has not yet been studied in workers' compensation populations.

In rare instances (estimated at 1.0-1.5 per million manipulations), manipulation has been associated with cerebrovascular accident. Some studies suggest that this risk is based on the position of the patient, not the act of manipulation itself. Serious side effects are extremely rare and far less frequent than those associated with commonly prescribed alternatives such as nonsteroidal anti-inflammatory drugs (NSAIDs), but the issue is currently under study and should be monitored.

Using cervical manipulation may be an option for patients with occupationally related neck pain or cervicogenic headache. Consistent with application of any passive manual approach in injury care, it is reasonable to incorporate it within the context of functional restoration rather than for pain control alone. There is insufficient evidence to support manipulation of patients with cervical radiculopathy.

• There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living.

• There is limited evidence that electromagnetic therapy may be effective to reduce pain in mechanical neck disorders. If used, there should be a trial period with objective signs of functional progress.

• Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints,[2] or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain.

• Injecting botulinum toxin (type A and B) has been shown to be effective in reducing pain and improving range of motion (ROM) in cervical dystonia (a disorder that is non-traumatic and non-work-related). Mild side effects were fairly common and dose dependent, including dry mouth and dysphagia. While existing evidence shows injecting botulinum toxin to be safe, caution is needed due to the scarcity of high-quality studies. There are no high quality studies that support its use in whiplash-associated disorder.

• Cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise.

• Other miscellaneous therapies have been evaluated and found to be ineffective or minimally effective. For example, cervical collars have not been shown to have any lasting benefit, except for comfort in the first few days of the clinical course in severe cases; in fact, weakness may result from prolonged use and will contribute to debilitation. Immobilization using collars and prolonged periods of rest are generally less effective than having patients maintain their usual, "preinjury" activities.

Physical Methods ACOEM GUIDELINES, 2ND. EDITION

Chapter 12, pages 298-301

LUMBAR SPINE SECTION

• Manipulation appears safe and effective in the first few weeks of back pain without radiculopathy. Of note is that most studies of manipulation have compared it with interventions other than therapeutic exercise, hence its value as compared with active, rather than passive, therapeutic options is unclear. Nonetheless, in the acute phases of injury manipulation may enhance patient mobilization. If manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated. For patients with symptoms lasting longer than one month, manipulation is probably safe but efficacy has not been proved.

• A trial of manipulation for patients with radiculopathy may also be an option. There is consensus on its utility among practitioners who perform it, when radiculopathy is not progressive, and large series and cohort studies suggest value for some forms of manipulation. Randomized trials are under way. As with any promising intervention in the absence of definitive high-quality evidence, careful attention to patient response to treatment is critical. Many passive and palliative interventions can provide relief in the short term but may risk treatment dependence without meaningful long-term benefit. Such interventions may be used to the extent they are aimed at facilitating return to normal functional activities, particularly work.

• Manipulation under anesthesia (MUA) cannot be recommended at the present time because high quality studies do not exist and the procedure has significant associated risks.

• Traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended.

• Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists.

• Acupuncture has not been found effective in the management of back pain, based on several high-quality studies, but there is anecdotal evidence of its success.

• Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain.

• There are conflicting studies concerning the effectiveness of prolotherapy, also known as sclerotherapy, in the low back. Lasting functional improvement has not been shown. The injections are invasive, may be painful to the patient, and are not generally accepted or widely used. Therefore, using prolotherapy for low back pain is not recommended.

• There is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks.

• Other miscellaneous therapies, such as magnet therapy, have been evaluated and found to be ineffective or minimally effective.

• Some studies support neuroreflexotherapy (the temporary implantation of epidermal devices in trigger points in the back and referred tender points in the ear), but the procedure is invasive, and some questions exist regarding its potential benefit versus risk and cost.

• Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief.

• Moderate evidence suggests that back schools have better short-term effects than other treatments for chronic low back pain, and that such schools are more effective in an occupational setting than in a non-occupational setting. No good evidence supports using back schools for prevention, as opposed to treatment.

• Behavioral therapy may be an effective treatment for patients with chronic low back pain, but it is still unknown what type of patient benefits most from what type of behavioral treatment. Some studies provide evidence that intensive multidisciplinary bio-psycho-social rehabilitation with a functional restoration approach improves pain and function.

American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition.

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The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. When a physician is responsible for performing an isolated assessment of an examinee's health or disability for an employer, business, or insurer, a limited examinee-physician relationship should be considered to exist. A referral may be for:

- **Consultation:** To aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient