



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: () Health Care Provider (X) Injured Employee () Insurance Carrier

Requestor's Name and Address:

Buena Vista Workskills
5445 La Sierra Dr. #204
Dallas, Texas 75231

MDR Tracking No.: M5-06-1684-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

ZNAT Insurance Company, Box 47

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "Services were medically necessary."

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

Respondent's Position Summary: "Zenith continues to believe that the disputed services were not medically necessary. Please contact Zenith once an IRO has been assigned to review this dispute..."

Principle Documentation:

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

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)
10-25-05 – 12-20-05	97545 WHCA, 97546 WHCA, 97750-FC	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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 reimbursement for the services involved in this dispute.

Findings and Decision by:

Medical Dispute Officer

7-28-06

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.

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:	M5-06-1684-01
Name of Patient:	
Name of URA/Payer:	Buena Vista Workskills
Name of Provider: (ER, Hospital, or Other Facility)	Buena Vista Workskills
Name of Physician: (Treating or Requesting)	Rita Sealy-Wirt, DC

July 10, 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

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Required medical examinations and reports, dated 7/11/05 and 8/3/05
3. Carrier reviews, dated 7/11/05 and 12/2/05
4. Statement of medical necessity from medical doctor, dated 2/3/06
5. Behavioral medicine consultation and report, dated 6/16/05
6. Work hardening daily progress notes, dated 10/25/05 through 12/14/05
7. Functional capacity evaluations, dated 11/9/05 and 12/20/05

CLINICAL HISTORY

Patient is a 54-year-old male custodian who, on ____, injured his lower back when he lifted a lazy Susan cabinet that weighed an estimated 25 to 30 pounds. Four days later, he was seen by the company doctor, diagnosed with a lumbar strain, and began physical therapy under their direction. He was returned to modified duty work on 4/22/05.

The claimant then presented himself on 5/6/05 to a doctor of chiropractic, who placed him on temporary total disability, began chiropractic care, and continued providing physical therapy. The provider ordered an MRI on 5/31/05 that revealed multi-level disc degeneration, disc bulges with thecal sac impingement, and spinal stenosis without nerve root impingement. The provider then ordered a behavioral health assessment that revealed an adjustment disorder with mixed anxiety.

REQUESTED SERVICE(S)

Work hardening (97545-WH-CA), work hardening each additional hour (97546-WH-CA), and functional capacity exam (97750-FC) for dates of service 10/25/05 through 12/20/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

First of all, no medical records for the care that was rendered prior to the initiation of the work hardening program from either the company doctor or the treating doctor of chiropractic were provided for review. Therefore, it is unknown what specific treatments had already been attempted, and what the responses to those treatments were.

Since no previous treatment records were submitted for review, there is no documentation that chiropractic spinal adjustments were performed at any time. According to the AHCPR1 guidelines, spinal manipulation was the only recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain; the British Medical Journal² reported that spinal manipulation combined with exercise yielded the greatest benefit; and JMPT³ reported that spinal manipulation may be the only treatment modality offering broad and significant long-term benefit for patients with chronic spinal pain syndromes. Therefore, since it is unknown whether or not the treating doctor ever attempted a proper regimen⁴ of this recommended form of treatment, the work hardening was premature and medically unnecessary.

Current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises, and there is no mention in the documentation submitted that the patient was ever prescribed a home exercise program. The literature

July 10, 2006

Notice of Independent Review Determination

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1 Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.

2 *UK Back pain Exercise And Manipulation (UK BEAM) randomised trial:*

Medical Research Council, British Medical Journal (online version) November 2004.

3 Muller, R. Giles, G.F. Long-term Follow-up of a Randomized Clinical Trial Assessing the Efficacy of Medication, Acupuncture, and Spinal Manipulation for Chronic Mechanical Spinal Pain Syndromes. *J Manipulative Physiol Ther* 2005;28:3-11.

4 Haas M, Group E, Kraemer DF. Dose-response for chiropractic care of chronic low back pain. *Spine J.* 2004 Sep-Oct;4(5):574-83. "There was a positive, clinically important effect of the number of chiropractic treatments for chronic low back pain on pain intensity and disability at 4 weeks. Relief was substantial for patients receiving care 3 to 4 times per week for 3 weeks."

goes on to state that there is also no strong evidence for the effectiveness of multidisciplinary rehabilitation as compared to usual care.”⁵ The literature further states “...that there appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities...”⁶ 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.⁷ Based on those studies, the work hardening program was not medically necessary.

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

⁵ 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.

⁶ 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.

⁷ Karjalainen K, et al. Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults. Cochrane Database of Systematic Reviews 2000;2.