



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	
Requestors Name and Address: Texas Health 5445 La Sierra Dr. #204 Dallas, Texas 75231	MDR Tracking No.: M5-06-1837-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: ACE Fire Underwriters Ins Co, Box 15	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "It is our position that Sedgwick has established an unfair and unreasonable time frame in paying for the services that 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

Position Summary: "The dates of service 7-5-05, 7-6-05, 7-7-05, 7-8-05 were denied as they were not medically necessary...the Claimant did not appear to show improvement during these sessions of work hardening. His pain levels were increasing and his activities were decreasing..."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. EOBs
3. Peer reviews

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)
7-5-05 – 7-7-05	97545-WH-CA 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Grand total		\$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.

On September 25, 2006 the Requestor submitted a Revised Table of Disputed Services which indicated that some services were being withdrawn. This Revised Table of Disputed Services will be used for this review.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the disputed medical necessity issues. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
28 Texas Administrative Code Sec, 133.308 and 134.1

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

10-09-06

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.



September 11, 2006

Re: MDR #: M5 06 1837 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: **Ace Fire Insurance Underwriters**

REQUESTOR: **Texas Health**

TREATING DOCTOR: **Erwin Cruz, MD**

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 DO/DC who is a 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 1837 01

Information Provided for Review:

1. Notes from Bradley Eames, D.O.
2. Notes from Edwin Cruz, M.D.
3. Notes from Phil Bohart, Counselor
4. Chronic pain management hypnotherapy notes
5. Work hardening notes commencing on 05/31/05
6. Psychotherapeutic notes
7. Notes from Concentra Medical Center
8. Notes from Mike Shah, M.D. These notes include his procedure notes for interventional injection therapy
9. Occupational and physical therapy notes
10. Report from Dr. Wong
11. Functional capacity evaluation report of 04/01/05

Clinical History:

The claimant is a 26-year-old male who reports sustaining an injury to his lower back while lifting at _____ on _____. He underwent an MRI scan showing bulging discs at L4/L5 and L5/S1. He had electrodiagnostic findings of a bilateral S1 radiculopathy. He received 4 lumbar epidural steroid injections as well as occupational and physical therapy, work hardening, chronic pain management, and psychotherapy.

Disputed Services:

Work hardening.

Decision:

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

Rationale:

It appears that the claimant has recalcitrant low back pain that did not respond favorably or completely to occupational therapy, physical therapy, or injection therapy. A functional capacity evaluation found him to still be unable to return to his former

occupational activities. He was found not to be at maximum medical improvement by Dr. Wong on 05/19/05. It is my belief that a trial of work hardening was reasonable. However, the 8 hours per day of work hardening, in my opinion, was not reasonable. It is my opinion that 1 hour of stretching, 1 hour of strengthening, 1 hour of cardiovascular condition, 2 hours of stabilization, 1 hour of functional activities, and 1 hour of group therapy as well as 1 hour of upper and lower extremity exercise is excessive and inconsistent with the needs of this gentleman. Typical work hardening programs for a single area of injury such as the lower back would typically not exceed 3-4 hours per day. It would not be reasonable to expect an injured worker to be able to participate in 7 hours of active exercise and 1 hour of group therapy on a daily basis, in my opinion. Work hardening for a 4-week trial would have been a reasonable proposition within the parameters discussed above.

The reason to support work hardening is based on the recalcitrant nature of his condition, the functional capacity evaluation, and the deficits noted by the therapist prior to entering work hardening. The 7-hour-per-day requirements of the treatment program is, in my opinion, excessive and not realistic to expect an injured worker to be able to participate in fully, and 3 to 4 hours is a more reasonable time frame.

Screening Criteria/Literature:

The criteria utilized in forming this opinion is based on my experience in treating patients with chronic back pain for 25 years, incorporating both chiropractic physical therapy, pain management strategies, functional capacity evaluations, and work hardening.