



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	
Requestors Name and Address: REHAB 2112 P O BOX 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M5-06-1878-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Rep Box # 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Services are medically necessary."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: No Position Summary was submitted to MDR by the Respondent.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

<u>Date(s) of Service</u>	<u>CPT Code(s) or Description</u>	<u>Medically Necessary?</u>	<u>Additional Amount Due (if any)</u>
07-25-05	97001 (1 unit @ \$97.70) * see note below	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$82.95
07-27-05, 07-29-05 and 08-03-05	97110 (1 unit @ \$36.14 X 3 units X 3 DOS) * see note below	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$325.23
08-05-05, 08-08-05, 08-10-05 & 08-12-05	97110 (1 unit @ \$36.14 X 4 units X 4 DOS) * see note below	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$578.20
08-17-05 to 08-23-05	97545-WH-CA (1 unit @ \$128.00 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$640.00
08-17-05 to 08-23-05	97546-WH-CA (1 unit @ \$64.00 X 5 units X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,600.00
08-17-05 & 08-19-05	97546-WH-CA (1 unit @ \$16.00 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$32.00
01-12-06	97750-FC (1 unit @ \$38.61 X 12 units) * see note below	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$444.00
	* Per Rule 134.202(d)(2) reimbursement shall be the least of the "health care provider's usual and customary charge"		
	<u>TOTAL DUE</u>		\$3,702.38

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 prevail** on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202(d)(2)
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 \$3,702.38. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the Respondent 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.

Order by:

10-05-06

Authorized Signature

Typed Name

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.

ZRC MEDICAL RESOLUTIONS

August 24, 2006

Re: MDR #: M5 06 1878 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:

REQUESTOR

Rehab 2112

TREATING DOCTOR: Ramesh Sanghani, 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 chiropractor who is board certified in chiropractic orthopedics and pain management 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 1878 01

Information Provided for Review:

1. Application for MDR, TWCC-60
2. Explanation of benefits for denied services
3. Multiple TWCC-73 forms
4. Report dated 06/21/05 by Dr. Lloyd Payne addressed to Argus Services Corporation
5. IME report drafted by Charles Graham, M.D. dated 06/30/05
6. Impairment rating report dated 09/09/05 by Raymond Troxler, M.D.
7. EMG report dated 09/13/05 by Dr. James Garrison
8. Addendum report dated 01/06/06 by Dr. Raymond Troxler
9. MDR request dated 06/21/06 by Dr. Ramesh Sanghani
10. Letter of medical necessity dated 03/29/06 for work hardening by Dr. Gerri Souder
11. MRI report of the lumbar spine dated 06/17/05
12. Referral for electrodiagnostic studies dated 06/08/05
13. Electrodiagnostic report dated 06/23/05 signed by Dr. Joseph Jenkins
14. Various notes from the therapist for activities performed during active care ranging in dates from 08/17/05 through 08/22/05
15. Various other therapy notes noted
16. Notes from Dr. Kenneth Wise, psychologist
17. Home exercise sheets
18. FCE report dated 01/12/06
19. Psychological notes dated 01/12/06,
20. Injury Impact Questionnaire, Stress and Lifestyle Change Survey, and Critical Item Questionnaire, all dated 01/12/06
21. FCE report dated 08/15/05
22. Stress and Lifestyle Survey and other psychological questionnaire forms that have been noted previously also dated 08/15/05
23. Various interoffice reports and forms
24. Examination finds from physical therapist dated 07/25/05
25. Summary of maximum physical job demands
26. Initial evaluation findings dated 06/14/05 signed by Dr. Sanghani
27. Re-evaluation examination findings dated 07/22/05
28. Treatment notes ranging from dates 06/15/05 to 07/21/05
29. Initial report dated 06/02/05
30. TWCC-1 dated
31. TWCC-41 dated
32. X-ray report of the lumbar spine dated 06/17/05
33. Records from Methodist Hospital dated 06/09/05

Clinical History:

The patient reports having slipped and fell, injuring his back. The patient presented to Methodist Hospital where he was evaluated and prescribed medications. The patient then sought the care of Dr. Ramish Sanghani where therapy was prescribed. The patient was referred out for x-rays of the lumbar spine as well as an MRI scan of the lumbar spine. The patient was also referred for electrodiagnostic studies, initially consisting of an NCV. The patient was placed in passive care and graduated into active care. The patient did undergo a functional capacity evaluation and was placed in work hardening for approximately 5 visits. A second FCE was performed, and the patient was released back to full duty.

Disputed Services:

The items in dispute by the carrier are therapeutic exercises 97110, physical therapy evaluation 97001, work hardening 97545-WH-CA, work hardening each additional hour 97546-WH-CA, and functional capacity evaluation 97750-FC.

Decision:

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

Rationale:

This patient did have an injury, and apparently there was a witness to this injury. The patient was treated with passive modalities and advanced into active care for a short period of time. The doctor did attempt to return the patient to light duty. The patient was then placed in a work hardening program after having a functional capacity evaluation. After 5 visits of work hardening, a follow-up functional capacity evaluation was performed. The patient did meet his job duty requirements and was returned back to work in very short course.

Screening Criteria/Literature:

My opinion is based on my professional experience as a clinician and treating chiropractor with 14 years experience. In addition to this, I did review the Mercy Guidelines, in particular Chapter 8 under frequency and duration of care. I also reviewed the National Guideline Clearing House for Musculoskeletal Injuries.