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: Injury 1 Treatment Center 5445 La Sierra Drive # 204 Dallas, Texas 75231	MDR Tracking No.: M5-06-2036-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Amerisure Mutual Insurance Company Rep 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: "In summary, it is our position that Amerisure has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to Mr. ___."

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: The Respondent did not submit a Position Summary to MDR.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-15-05 to 11-02-05	97545-WC-CA, 97545-WH-CA, 97546-WC-CA and 97546-WH-CA	☐ Yes ☒ No	$0.00
	TOTAL DUE		$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 and 134.1
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS AND 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 and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

		10-05-06
Authorized Signature		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 Austin, Texas 78735
Phone: 512-288-3300 FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 10/2/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-2036-01
Name of Patient:	
Name of URA/Payer:	Injury One Treatment Center
Name of Provider: (ER, Hospital, or Other Facility)	Injury One Treatment Center
Name of Physician: (Treating or Requesting)	Cody Doyle, DC

September 18, 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

REVISED 10/2/06

DOCUMENTS REVIEWED

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Orthopedic surgeon's follow-up notes, multiple dates
3. Treating doctor's initial examination and narrative report, dated 5/12/05
4. Designated doctor examination, report and DWC-69, dated 5/6/05
5. Treating doctor's subsequent examination and reports, dated 6/21/05
6. Treating doctor's "daily progress and procedural notes" and "therapeutic procedures charts," multiple dates
7. Letters of medical necessity from the work hardening provider, dated 9/14/05 and 2/27/06
8. Letter of medical necessity from the treating doctor of chiropractic, dated 11/22/05
9. Carrier reviews, dated 9/21/05 and 10/25/05
10. Required medical examination and report, and requested FCE, all dated 4/4/05

11. CT scan and report of left calcaneus, dated 10/28/04
12. Initial evaluation for work conditioning program, performed by referral physician, dated 8/10/05
13. Follow-up work conditioning notes and narratives from referral physician, multiple dates
14. Work conditioning daily notes, daily flow sheets, psychotherapeutic group notes, and interdisciplinary group therapy notes, multiple dates
15. Work hardening daily notes, daily flow sheets, psychotherapeutic group notes, lunch hour psychotherapeutic group notes, and interdisciplinary group notes, multiple dates
16. Physical therapy evaluation and report, dated 7/20/05
17. Functional capacity evaluations, dated 7/20/05, 9/8/05, 10/10/05, 10/28/05, 11/8/05, 11/9/05
18. Behavioral medicine consultation and report, dated 8/31/05
19. Reconsideration request from work hardening provider, dated 11/28/05
20. Various CMS 1500 and DWC-73 forms

CLINICAL HISTORY

Patient is a 30-year-old male dry wall worker who, on ___, fell approximately 10 feet from a ladder, landed, and struck his foot on an iron beam, causing a comminuted fracture of his left calcaneus. He underwent open reduction and internal fixation of the left calcaneus on 11/10/04. Following the claimant's surgery, he underwent a course of post-operative physical therapy.

Due to continued pain, he changed treating doctors on 5/12/05 to a doctor of chiropractic who assumed direction of his physical therapy program. The records reveal that he performed manipulation, neuromuscular reeducation, and supervised therapeutic and kinetic exercises. When his response was less than desired, the treating doctor then referred the claimant for a functional capacity evaluation led to a work-conditioning program. A work hardening program then followed a brief work-conditioning program.

REQUESTED SERVICE(S)

Work conditioning/ work hardening program (97545-WCCA/97545-WH-CA), and work conditioning/ work hardening, each additional hour (97546-WCCA/97546-WH-CA), and physical performance testing (97750) for dates of service 8/15/05 through 11/02/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

The claimant in this case was seen by a designated doctor—who carries presumptive weight—on 5/12/05 that was right at the time he began seeing the doctor of chiropractic. Based on that examination, it was the designated doctor's opinion that the claimant was already at clinical MMI, and was capable of working at a reduced capacity by limiting walking. In addition, the records included a functional capacity evaluation performed on 4/4/05 that found the claimant capable of performing work at a "medium" PDL. Therefore, based on those facts, the medical necessity of the work hardening/ work conditioning program as well as the physical performance testing after that date was questionable.

In the preamble of the Texas Workers Compensation Commission's amendments to rule 134.600, the Commission states as follows: "Over-utilization of medical care can both endanger the health of injured workers and unnecessarily inflate system costs. Unnecessary and inappropriate health care does not benefit the injured employee or the workers' compensation system. Unnecessary treatment may place the injured worker at medical risk, cause loss of income, and may lead to a disability mindset. Unnecessary or inappropriate treatment can cause an acute or chronic condition to develop." In its report to the legislature, the Research and Oversight Council on Texas Workers' Compensation explained its higher costs compared to other health care delivery systems by stating, "Additional differences between Texas workers' compensation and Texas group health systems also widen the cost gap. These differences include…in the case of workers' compensation, the inclusion of costly and questionable medical services (e.g., work hardening/conditioning.)" In this case, the provider's work hardening/ work conditioning program is just the type of questionable services of which the TWCC and the legislature spoke when expressing concern in regard to medically unnecessary treatments that may place the injured worker at medical risk, create disability mindset, and unnecessarily inflate system costs.

Current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises. There is also no strong evidence for the effectiveness of multidisciplinary rehabilitation as compared to usual care."

The literature further states "…that there appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities..." Additionally, 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. Based on those studies, the claimant's work hardening/ work conditioning program was unsupported as medically necessary.

Finally, the minimal change that was recorded from the functional capacity evaluation (FCE) performed on 9/8/05—near the onset of the care in question—compared to the final FCE performed on 11/8/05 was insignificant in terms of the pain reduction and range of motion improvements. Specifically, the "numeric pain profile" only decreased from 8.6/10 to 7.6/10; range of motion stayed the same on foot inversion; foot eversion only increased to 6 degrees; plantar flexion only increased from 39 degrees to 45 degrees; and dorsiflexion only increased 1 degree from 12 to 13 degrees

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