



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier		
Requestor=s Name and Address:	MDR Tracking No.: M5-07-0111-01	
Rehab 2112 P. O. Box 671342 Dallas, TX 75267-1342	Claim No.:	
	Injured Employee's Name:	
Respondent's Name and Address:	Date of Injury:	
	LIBERTY INSURANCE CORP, Box 28	Employer's Name:
	Insurance Carrier's No.:	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary (Table of Disputed Services) states, "Work hardening was medically necessary."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. DWC-60/Table of Disputed Service

Position summary (Table of Disputed Services) states, "Billed charges are denied per peer review. Payment has been issued for 12 visits and review only recommended 11 visits."

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)
12-12-05 – 12-19-05	97545-WH-CA (\$128.00 x 3 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$384.00
12-12-05 – 12-19-05	97546-WH-CA (\$64.00 x 13.25 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$848.00
12-23-05 – 1-11-06	97545-WH-CA, 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total		\$1,232.00

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 majority of the disputed medical necessity issues. The amount due the Requestor for the items denied for medical necessity is \$1,232.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202
Texas Labor Code 413.011 and 413.031

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 a refund of the paid IRO fee. The Division has determined that the Requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$1,232.00. 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.

Findings and Decision and Order by:

Medical Dispute Officer

2-13-07

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.

RYCO MedReview

DETERMINATION OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-07-0111-01
NAME OF REQUESTOR: Rehab 2112
NAME OF PROVIDER: Patricia Clawson Johnson, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5345
DATE OF REPORT: 12/08/06

Dear Rehab 2112:

RYCO MedReview has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5345). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to RYCO MedReview for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a health care professional or physician reviewer who is Licensed by the Texas State Board of Chiropractic Examiners and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of RYCO MedReview 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 the provider, 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.

REVIEWER REPORT

Information Provided for Review:

Evaluations with Victor Peralta, M.D. dated 09/08/05 and 09/12/05
TWCC-73 forms from Dr. Peralta dated 09/08/05 and 09/12/05
Evaluations with Patricia Johnson, D.C. dated 09/13/05, 09/14/05, 09/23/05, 09/27/05, and 10/25/05
X-rays of the lumbar spine interpreted by Kenneth Lustik, D.C. dated 09/14/05 and 09/28/05
X-rays interpreted by Dr. Johnson dated 09/14/05
TWCC-73 forms from Dr. Johnson dated 09/14/05 and 11/09/05
Letters from Lee Boehm, P.T. dated 09/14/05 and 09/15/05
A treatment plan from Dr. Johnson dated 09/14/05
Chiropractic therapy with Dr. Johnson dated 09/15/05, 09/16/05, 09/17/05, 09/19/05, 09/20/05, 09/21/05, 09/22/05, 09/23/05, 09/26/05, 10/03/05, 10/04/05, 10/05/05, 10/11/05, 10/12/05, 10/14/05, 10/17/05, 10/18/05, 10/19/05, 10/21/05, 10/24/05, 10/28/05, 10/31/05, 11/02/05, 11/07/05, 11/09/05, 11/28/05, 12/05/05, 12/12/05, 12/19/05, and 01/09/06
An MRI of the lumbar spine interpreted by Dr. Lustik dated 09/16/05
An undated TWCC-53 form from Dr. Johnson
X-rays of the thoracic spine interpreted by Dr. Lustik dated 09/28/05
A note from Dr. Johnson dated 10/25/05
Evaluations with Tony Bennett, D.C. dated 10/25/05 and 10/27/05
A Work Program Participant Intake Sheet dated 10/27/05
A Functional Capacity Evaluation (FCE) with Dr. Bennett dated 10/31/05
A Stress and Lifestyle-Change Survey from the patient dated 10/31/05
An evaluation with Kenneth F. Wise, Psy.D. dated 11/02/05
Work hardening notes with an unknown provider (the signature was illegible) dated 11/07/05, 11/08/05, 11/09/05, 11/10/05, 11/11/05, 11/14/05, 11/16/05, 11/17/05, 11/18/05, 11/21/05, 11/22/05, 11/23/05, 11/28/05, 11/30/05, 12/02/05, 12/05/05, 12/07/05, 12/09/05, 12/12/05, 12/14/05, 12/16/05, 12/19/05, 12/23/05, 12/28/05, 12/29/05, 12/30/05, 01/04/06, 01/09/06, and 01/11/06
Notes from the unknown provider dated 11/08/05, 11/18/05, 11/23/05, 12/09/05, and 01/06/06
A Notice to Carrier of Injury form from TDI dated 11/17/05
Group psychotherapy with Dr. Wise dated 11/30/05, 12/14/05, 12/23/05, 01/04/06, and 01/11/06
Billing Retrospective Reviews from Thomas B. Sato, D.C. dated 12/02/05 and 12/13/05
DWC-73 forms from Farid Aminzadeh, D.C. dated 12/05/05 and 01/09/06
A Functional Capacity Evaluation (FCE) with Thomas R. Rhudy, D.C. dated 12/21/05
An EMG/NCV study interpreted by Joseph Jenkins, D.C. dated 12/21/05
Notes from Dr. Rhudy dated 11/25/05, 01/13/06, 01/16/06, and 01/18/06
A Field Investigator Activity Check Report from an unknown provider (no name or signature was available) dated 01/17/06
A letter from Dr. Aminzadeh dated 02/06/06
A Designated Doctor Evaluation with Christine Huynh, M.D. dated 02/28/06
A letter of medical necessity from Gerri Souder, D.C. dated 03/13/06
A Notification of Maximum Improvement/First Impairment Income Benefit Payment dated 03/21/06
A Medical Dispute Resolution Request from Dr. Aminzadeh dated 06/29/06

Clinical History Summarized:

On 09/08/05, Dr. Peralta recommended Hydrocodone/APAP, Tylenol, Biofreeze gel, Flexeril, physical therapy, and modified work duty. X-rays of the lumbar spine interpreted by Dr. Lustik on 09/14/05 and 09/28/05 revealed only postural alterations. Chiropractic therapy was performed with Dr. Johnson from 09/15/05 through 01/09/06 for a total of 30 sessions. An MRI of the lumbar spine interpreted by Dr. Lustik revealed a broad based shallow disc protrusion at L5-S1. X-rays of the thoracic spine interpreted by Dr. Lustik on 09/28/05 also revealed postural alterations. An FCE with Dr. Bennett on 10/31/05 indicated the patient could function at the medium physical demand level. Work hardening was performed with the unknown provider from 11/07/05 through 01/11/06 for a total of 29 sessions. Group psychotherapy was performed with Dr. Wise from 11/30/05 through 01/11/06 for a total of five sessions. On 12/02/05, Dr. Sato recommended no further chiropractic care with a return to work program. On

12/13/05, Dr. Soto recommended an FCE and continuation of the work hardening program. An FCE with Dr. Rhudy on 12/21/05 indicated the patient still functioned at the medium physical demand level. An EMG/NCV study interpreted by Dr. Jenkins on 12/21/05 revealed possible systemic peripheral neuropathy and mild chronic L5 and S1 nerve root radiculopathy on the left. On 02/06/06, Dr. Aminzadeh noted the patient had missed continuous appointments. On 02/28/06, Dr. Huynh placed the patient at Maximum Medical Improvement (MMI) with a 5% whole person impairment rating. On 03/13/06, Dr. Souder wrote a letter of medical necessity requesting reconsideration and providing compensation. On 06/29/06, Dr. Aminzadeh provided a Medical Dispute Resolution Request.

Disputed Services:

Work hardening (97545-WH-CA) and work hardening each additional hour (97546-WH-CA) from 12/12/05 through 01/11/06

Decision:

I partially agree with the requestor. The work hardening (97545-WH-CA) and work hardening each additional hour (97546-WH-CA) from 12/12/05 through 12/21/05 was reasonable and necessary. However, the work hardening (97545-WH-CA) and work hardening each additional hour (97546-WH-CA) from 12/21/05 through 01/11/06 was not reasonable or necessary.

Rationale/Basis for Decision:

Based upon the supplied documentation, a work hardening program would be reasonable and necessary from 12/12/05 through 12/21/05. Treatment from 12/21/05 through 01/11/06 would not be reasonable and necessary based upon the fact that the patient was non-compliant with the recommended treatment program and the fact that a Functional Capacity Evaluation (FCE) performed on 12/21/05 indicated the patient's condition had not progressed secondary to the previous 15 work hardening visits. Therefore, based upon non-compliance with the recommended treatment and the patient's failure to show improvement provided by such treatment, any treatment performed after 12/21/05 with regard to work hardening would not be considered medically reasonable and necessary.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for RYCO MedReview is deemed to be a Division decision and order.

YOUR RIGHT TO REQUEST A HEARING

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.

A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 12/08/06 from the office of RYCO MedReview.

Sincerely,

Amanda Thomas
Secretary/General Counsel