



**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:  Rehab 2112 P. O. Box 671342 Dallas, TX 75267-1342	MDR Tracking No.: M5-07-0256-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  INDEMNITY INSURANCE CO OF NORTH, BOX 15	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

**PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Position Summary (Table of Disputed Services): "Work Hardening was medically necessary."

Principle Documentation:

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

**PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

No position statement was submitted by the Respondent.

**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)
11-01-05 – 12-19-05	97545-WH-CA, 97546-WH-CA, 97750-FC	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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. 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:**

01-31-07

\_\_\_\_\_  
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.**

SENT TO: Texas Department of Insurance  
Health & Workers' Compensation Network Certification & QA  
Division (HWCN) MC 103-5A  
Fax: 512.904.4868

01/24/07

RE: IRO Case #: M5.07.0256.01  
Name: \_\_\_\_\_  
Coverage Type: Workers' Compensation Health Care - Non- network  
Type of Review:  
\_\_\_\_ Preauthorization  
\_\_\_\_ Concurrent Review  
 Retrospective Review  
Prevailing Party:  
\_\_\_\_ Requestor  
 Carrier

ZRC Medical Resolutions, Inc. (ZRC) has been certified, IRO Certificate #5340, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to ZRC for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

ZRC has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, ZRC reviewed the medical records and documentation provided to ZRC by involved parties.

This case was reviewed by a D.C., C.C.S.P, F.I.A.C.T., and specially trained in both ventilation of anesthesia and certification in peer review through the National University of Health Sciences. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), and any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of ZRC, I certify that:

1. there is no known conflict between the reviewer, ZRC and/or any officer/employee of ZRC with any person or entity that is a party to the dispute, and
2. a copy of this IRO decision was sent to all of the parties via U.S. Postal service or otherwise transmitted in the manner indicated above on 01/24/07.

**RIGHT TO APPEAL:**

You have the right to appeal the decision by seeking judicial review. This IRO decision is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery, the appeal must be filed:

1. directly with a district court in Travis County (see Labor Code 413.031(m)), and
2. within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to prospective or concurrent review of spinal surgery, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

Jeff Cunningham, D.C.  
President/CEO

**REVIEWER REPORT  
M5 07 0256 01**

**DATE OF REVIEW:** 01/19/07

**IRO CASE #:** M5-07-0256-01

**DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:**

D.C., C.C.S.P, F.I.A.C.T., and specially trained in both ventilation of anesthesia and certification in peer review through the National University of Health Sciences

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

There were 582 pages submitted for review including but not limited to seven pages of the DWC-64, 11 pages of EOBs, and the remaining 564 pages of documentation

including daily work hardening and SOAP notes, MRI reports, psychological evaluations, and visit log reports.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This case involves a 27-year-old female who was involved in a motor vehicle accident on \_\_\_ while on the job. Initial complaints involved the cervical spine, thoracic spine, lumbar spine, and left shoulder.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

Use of such guidelines such as ACOEM and the ODG Guidelines provide little information, as they do not propose any guidelines for rehabilitation or work hardening treatments.

The clinic states on page six of the documents in the fourth paragraph, “The efforts which were expanded in the management of conditions suffered by this patient or directed toward accomplishing, among other things, the following: (1) decreasing edema; (2) decreasing pain; (3) decreasing the amount of scar formation; (4) restoration of joint function; (5) restoration of joint motion; (6) achieving pre-accident status or maximum medical improvement in an expeditious manner.”

Later on page ten of the documents supplied, the requestor also quotes Texas Labor Code Section 408.021 and 401.011. Section 408.021 states, “An employee who sustains a compensable injury is entitled to all healthcare reasonably required by the nature of the injury when needed. The employee is specifically entitled to healthcare that (1) cures or relieves the effects naturally resolving from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or obtain employment.” Section 401.011 of the Texas Labor Code states, “Healthcare includes all reasonable and necessary medical services.”

On page two of the MDR request, there is a report dated 10/30/06 which states that the patient complained of neck pain with a scale of 6/10 pain, upper back pain with a pain level of 6/10, lower back/sacroiliac joint pain with pain level of 6/10, left arm pain with a pain level of 5/10, and left chest pain with a pain level of 3/10. On page three of this report, the cervical range of motion was slightly diminished, and the thoracolumbar range of motion was slightly diminished. The examiner also reports that the remaining muscles tested appeared to be at +5 strength, which is normal, and reflexes were at 2+ bilaterally, which is also normal. He also states that sensation appeared to be intact, and the muscle tone was good.

The patient subsequently underwent a course of passive care, which was later changed to active care and rehabilitation to include work hardening. However, on the last day in dispute, which is 12/16/05 as reflected on page 140 of the documents, one will note that the subjective patient is complaining of pain rating a 7/10 pain. There are also numerous weeks proceeding where the pain level fluctuated between 7/10-8/10 or 10/10, which is actually a worsening of the pain from when the patient initially presented. The

physician's own notes reflect that after an extensive course of passive care followed by work hardening, the patient was actually worse than when he initially presented, which would not follow the Texas Labor Code. One would expect that over a period of time the pain would lessen, and the range of motion would increase. In this instance, there was a mildly decreased range of motion which did not substantially change. The muscle strengths were all 5+, and reflexes were all 2+. The patient's doctor states that the muscle tone was good, and highest level of pain was in the cervical, thoracic, and lumbar spine, which was 6/10. According to these supplied notes, approximately six months post injury, there is substantially no change in the patient's range of motion, the muscle strength is still 5+, and deep tendon reflexes are still 2+. However, the patient was experiencing more pain six months post injury.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- AHCPR-Agency for Healthcare Research & Quality Guidelines.
- DWC-Division of Workers' Compensation Policies or Guidelines.
- European Guidelines for Management of Chronic Low Back Pain.
- Interqual Criteria.
- Medical judgement, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines:
  - Texas Labor Code Section 408.021 and Section 408.011