

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Rehab 2112 P O BOX 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M5-05-2635-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Insurance Company Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
06-02-04	06-25-04	97545-WH-CA and 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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 IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review 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:

Authorized Signature

08-09-05

Date of Decision

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: 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. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 8, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-05-2635-01
IRO Certificate #: IRO 5263

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Table of disputed services
- HCFA 1500's
- EOBs
- Work hardening notes
- Exercise logs
- Daily notes
- Therapy notes
- FCE reports
- Counseling notes
- Job description reports
- Initial examination reports
- Patient satisfaction surveys
- Super bills
- Examination reports
- TWCC forms
- Insurance information

Submitted by Respondent:

- None supplied

Clinical History

According to the supplied documentation, the claimant sustained an injury on _____. While working she noticed pain in her right wrist. The claimant reports looking at her right wrist and noticed that it had “swollen up”. The claimant reported to Accident and Injury Chiropractic on 3/29/04. The claimant was diagnosed with a sprain/strain and began therapy. On 4/5/04 a right wrist x-ray was considered unremarkable. On 4/5/04 a right wrist MRI was considered unremarkable. On 6/1/04 an FCE was performed that placed the claimant at the light job duty physical demand level which matched her current level of employment. The claimant underwent work hardening protocol during June 2004. The documentation ends here.

Requested Service(s)

Work hardening program for dates of service 6/2/04 to 6/25/04

Decision

I agree with the carrier that the services in dispute were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the claimant sustained a sprain/strain injury while at work on _____. All of the diagnostic tests supplied for review, including the x-ray and MRI, revealed no abnormal findings. This would limit the amount of therapy that would be considered reasonable and medically necessary for the compensable injury. According to the Official Disability Guidelines, a sprain/strain of the wrist would be limited to 9 visits over an 8 week period. This is according to the physical therapy guidelines. Since the FCE revealed that the claimant was able to perform her job at her current level and with negative diagnostic studies, a short term of passive therapies would be indicated and followed by a home based exercise protocol. The documentation supplied reveals the claimant was given some exercises to use with some Theraputty which appears reasonable and acceptable for the compensable injury. None of the work hardening prescribed in this case is objectively supported in the documentation supplied.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 8th day of August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder