

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestor's Name and Address  North Texas Pain Recovery Center 6702 West Poly Webb Road Arlington, Texas 76016	MDR Tracking No.: M5-05-2871-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  Lumbermen's Mutual % Pam Greer, Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY SERVICES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
11-01-04	11-05-04	CPT code 97545-WHCA, 97546-WHCA	<input checked="" type="checkbox"/> Yes <input 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 **prevailed** on the disputed medical necessity issues. The amount due the requestor for the medical necessity services is \$2,432.00.

### PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$650.00. The Division hereby **ORDERS** the insurance carrier to remit \$2,432.00, consistent with the applicable fee guidelines plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

8-17-05

Authorized Signature

Typed Name

Date of Order

### 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.

+

August 12, 2005

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-05-2871-01  
TWCC#: \_\_\_\_\_  
Injured Employee: \_\_\_\_\_  
DOI: \_\_\_\_\_  
SS#: \_\_\_\_\_  
IRO Certificate No.: IRO 5055

Dear \_\_\_\_:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI 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 Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to 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. This case was reviewed by a physician who is board certified in Neurology and in Pain Management, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme  
General Counsel

GP:thh

**REVIEWER'S REPORT**  
**M5-05-2871-01**

---

**Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Daily progress notes 11/01/04 – 11/05/04

Therapy notes 11/01/04 – 11/05/04

FCE 10/08/04 – 11/18/04

**Clinical History:**

This claimant sustained a work-related injury on \_\_\_ resulting in chronic pain from carpal tunnel syndrome. The claimant was eventually sent for a work hardening program that took place from 10/18/04 through 11/12/04. There is documentation indicating that the claimant had improvement in his functional capacity evaluation after the work hardening when compared to an earlier evaluation, and that the claimant has returned to work after having been discharged from work hardening and entering a vocational training program.

**Disputed Services:**

Work hardening program (97545 and 97546) during the period of 11/01/04 thru 11/05/04.

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the work hardening program in dispute as stated above was medically necessary in this case.

**Rationale:**

A communication dated 07/21/05 adequately summarizes the reviewer's thoughts on this matter. If indeed the work hardening program has been deemed medically necessary and is not being disputed for the weeks prior to and the week after the disputed dates, the reviewer can find no reason to indicate that the work hardening between the dates of 11/01/04 to 11/05/04 would be "unnecessary." In fact, the reviewer agrees with the remark that it "makes no sense" that this particular 5 day period would be thought to be medically unnecessary when the weeks before and after this time period are not in dispute. Additionally, it appears that this claimant has benefited from his participation in the work hardening program from the limited documentation that has been made available.