



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: <b>HighPoint Rehabilitation Institute</b> <b>800 W Arbrogk Blvd Suite 330</b> <b>Arlington TX 76015</b>	MDR Tracking No.: M5-06-0142-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: <b>American Casualty Co of Reading Box 47</b>	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DWC-60 package, EOBs, CMS-1500s. Position Summary: Services medically necessary.

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

DWC-60 response.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-14-04 to 10-14-04 except 9-17-04	97545-WC-CA (\$ 72.00 x 15 days = \$1,080.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,080.00
	97546-WC-CA (\$ 72.00 x 10 days = \$720.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$720.00
	97546-WC-CA (\$108.00 x 4 days = \$432.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$432.00
	97546-WC-CA (\$144.00 x 1 day = \$144.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$144.00
	97750-FC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$285.28
<b>TOTAL</b>			<b>\$2,661.28</b>

#### 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 **prevailed** on the disputed medical necessity issues.

The table of disputed services lists work conditioning for date of service 9-17-04. Carrier states they did not receive a bill for this date of service. The daily notes include dates of service 9-14-04, 9-15-04, 9-16-04, and 9-20-04 to 10-11-04. The requestor did not submit convincing evidence of carrier receipt of request for reconsideration per Rule 133.308. Therefore, this date will not be part of this review. No reimbursement recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.202

**PART VII: DIVISION DECISION AND ORDER**

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 entitled to additional reimbursement in the amount of \$2,661.28.

In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier 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.

Ordered by:

\_\_\_\_\_, Medical Dispute Officer

11-18-05

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

# P-IRO

An Independent Review Organization  
7626 Parkview Circle  
Austin, Texas 78731  
**Phone: 512-346-5040**  
**Fax: 512-692-2924**

November 11, 2005  
TDI-DWC Medical Dispute Resolution  
Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee \_\_\_\_\_  
TDI-DWC # \_\_\_\_\_  
MDR Tracking #: M5-06-0142-01  
IRO #: 5312

P-IRO, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to P-IRO for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

P-IRO has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL). The P-IRO Panel Member/Reviewer is a health care professional who 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, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including:

1. Medical Dispute Resolution Request.
2. Table of Disputed Services.
3. Revised Explanation of Review.
4. Initial Report from Crowne Chiropractic Clinic, 5-12-03.
5. Chart Notes from Crowne Chiropractic Clinic, 6-2-03 through 10-29-04.
6. Upper Extremity Electrodiagnostic Study, 2-9-04.
7. Medical reports from J. Rosenstein, M.D., 6-22-04 through 12-27-04.
8. IME report by Peter Foom, M.D., 7-26-04.
9. Addendum from Peter Foom, M.D., 8-4-04.
10. Work Conditioning Progress Reports, 9-14-04 through 10-11-04.
11. FCE, 10-14-04.
12. Impairment Rating by J. Van Beest, D.C., 10-18-04.
13. Medical report from James Box, M.D., 10-20-04.
14. Medical report from James Box, M.D., 5-19-05.
15. Peer Review from Mike O'Kelley, D.C., 7-9-05.  
Request for Reconsideration Report from J. Van Beest, D.C., 7-29-05

## **CLINICAL HISTORY**

The Patient reported bilateral wrist pain related to working as a pharmacy tech on \_\_\_\_\_. The Patient was initially managed by Gordon McWatt, D.O. who prescribed an anti-inflammatory and returned The Patient to work modified duty.

The Patient began chiropractic/physical therapy treatment at the Crowne Chiropractic Clinic on 5-12-03. Diagnoses included bilateral wrist sprain, rule out tenosynovitis, rule out left and right carpal tunnel syndrome, and rule out right ulnar neuritis.

After nine months of conservative chiropractic/physical therapy treatment, upper extremity electrodiagnostic testing was performed on 2-9-04. There was no evidence of radiculopathy noted.

After 10 months of chiropractic treatment, right carpal tunnel release was performed on 3-22-04. After more than one year of chiropractic treatment, a left carpal tunnel release was performed on 5-21-04.

After six months of post-operative rehabilitation following the right carpal tunnel release and four months of post-operative rehabilitation following the left carpal tunnel release, a Work Conditioning Program was performed from 9-14-04 through 10-11-04.

A Functional Capacity Evaluation was performed on 10-14-04. The Patient demonstrated tolerance for work in the Light Physical Demand Level for lifting and carrying tasks and light-medium Physical Demand Level for pulling.

An Impairment Rating was performed on 10-18-04 by Dr. Van Beest. The Patient was determined to have reached maximum medical improvement on 10-18-04 and assigned 4% WPI.

The Patient was evaluated by James Box, M.D. on 10-20-04. The Patient was not working. Current medication included Flexoril and Daypro. The Patient reported intermittent shooting pains in her right wrist and left wrist. Numerical pain scale was 4/10. She noted numbness in the fingertips at times. Range of motion of the wrists was normal. MMT was unremarkable. Grip and pinch strength was symmetrical.

## **DISPUTED SERVICE (S)**

Under dispute is the retrospective medical necessity of Work Conditioning (97545 and 97546) from 9-14-04 through 10-11-04 and FCE (97750) dated 10-14-04.

## **DETERMINATION / DECISION**

The Reviewer disagrees with the determination of the insurance carrier.

## **RATIONALE/BASIS FOR THE DECISION**

The documentation from multiple health-care providers involved in this case and the documentation from a few independent reviewers clearly indicates The Patient therapeutically benefited from the Work Conditioning Program from 9-14-04 through 10-11-04. In fact, it appears the only treatment pre-operatively and post-operatively that resulted in quantified and objectively measurable improvement was the Work Conditioning Program between 9-14-04 and 10-11-04. Improvements included subjective reports of pain, range of motion, strength testing, Grip strength, and Pinch strength. In other words, there is clearly strong and consistent inter-tester documentation of therapeutic benefit. Interestingly, the documentation from Dr. Van Beest's office certainly does not demonstrate lasting therapeutic benefit to support the protracted course of pre-operative and post-operative rehabilitation.

## **Screening Criteria**

### **1. General:**

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

## CERTIFICATION BY OFFICER

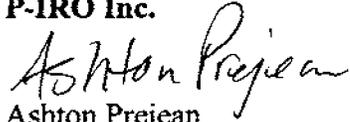
P-IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. P-IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of P-IRO Inc., I certify that there is no known conflict between the Reviewer, P-IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

P-IRO is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

**P-IRO Inc.**

A handwritten signature in black ink that reads "Ashton Prejean". The signature is written in a cursive, slightly slanted style.

Ashton Prejean

**President & Chief Resolutions Officer**