



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Buena Vista Workskills 5445 La Sierra Dr # 204 Dallas, Texas 75231	MDR Tracking No.: M5-06-0981-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Travelers Casualty & Surety Company Box 05	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package
POSITION SUMMARY: "Services were medically necessary"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received from Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
04-12-05 to 05-24-05	97545-WH-CA (1 unit @ \$128.00 X 5 DOS) = \$640.00 97546-WH-CA (6 units @ \$384.00 X 3 DOS) = \$1,152.00 97546-WH-CA (5.75 units @ \$368.00 X 2 DOS)= \$736.00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,528.00

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

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1)

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 reimbursement in the amount of \$2,528.00. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$650.00). 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:

03-15-06

Authorized Signature

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.



CompPartners Final Report ACCREDITED
EXTERNAL REVIEW

CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: _____
Texas IRO # : _____
MDR #: M5-06-0981-01
Social Security #: _____
Treating Provider: Robert Lowry, MD
Review: Chart
State: TX
Date Completed: 3/14/06

Review Data:

- Notification of IRO Assignment dated 2/23/06, 1 page.
- Receipt of Request dated 2/23/06, 1 page.
- List of Treating Providers (date unspecified), 1 page.
- Medical Dispute Resolution Request/Response dated 1/24/06, 1 page.
- Table of Disputed Services dated 5/24/05, 5/23/05, 5/9/05, 4/14/05, 4/12/05 1 page.
- Explanation of Benefits dated 5/23/05, 5/9/05, 4/14/05, 4/12/05, 4 pages.
- Invoice dated 2/27/06, 1 page.
- Examination dated 11/10/05, 2 pages.
- Behavioral Medicine Consultation dated 12/17/04, 7 pages.
- Initial Functional Capacity Evaluation dated 12/7/04, 7 pages.
- Second Functional Capacity Evaluation dated 3/14/05, 7 pages.
- Work Hardening Daily Progress Notes dated 5/24/05, 5/23/05, 5/9/05, 4/14/05, 4/12/05, 5 pages.
- Work Hardening Daily Flow Sheet (date unspecified), 20 pages.
- Group Psychotherapy Progress Note dated 5/24/05, 5/23/05, 5/9/05, 4/14/05, 4/12/05, 5 pages.
- Third Functional Capacity Evaluation dated 5/25/05, 6 pages.
- Patient Symptom Rating Scale dated 5/24/05, 1 page.
- Delivery Confirmation Receipt (date unspecified), 1 page.

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for a work hardening program. Dates of service: 4/12/05 through 5/24/05.

Determination: REVERSED - previously denied request for a work hardening program. Dates of service: 4/12/05 through 5/24/05.

Rationale:

Patient's age:

Gender:

Date of Injury: _____

Mechanism of Injury: The claimant hit his left hand with metal piece and due to repetitive motion, left hand became swollen with associated numbness and aching, with burning and stabbing pains radiating into the left upper extremity.

Diagnoses: Fracture of the left hand.

Subsequent to the injury, a reported X-ray of the left hand revealed a fracture, which was placed in a cast and the patient was given medication for possibly two weeks. The claimant continued with pain and swelling in the left hand and was referred to a

hand specialist, who performed a surgery to repair torn ligament in the left hand on September 9, 2004. Then, the patient underwent postsurgical physical therapy for approximately one month and initial functional capacity evaluation (FCE) performed on December 7, 2004. The claimant was able to function at a sedentary physical demand level (PDL) above and below the waist. However, the patient's job required a medium PDL. The patient's ability to recover and rehabilitate effectively in a timely manner was influenced by persistent physical pain, injury related psychosocial stressors, and economic distress, which was reported in behavioral medicine consultation/evaluation dated December 17, 2004. The claimant was determined a suitable candidate for CARF accredited work hardening program, which began on April 12, 2005. Following 10 days of treatment, the documentation reflected a progressive improvement with behavioral, attitudinal, and vocational functioning. A second FCE performed on March 14, 2005 revealed increase in functional ability from sedentary to light physical. The claimant underwent a requested 10 more days of work hardening program, which was completed on May 25, 2005. At that time, a third FCE was performed, which revealed left hand grip strength increased up 37 pounds, a decrease in anxiety of 30%, and decrease in pain level of almost 50%. The patient met the required return to work PDL of medium.

With the overall in-depth treatment this patient had received, it is the reviewer's recommendation that 20 sessions of work hardening was reasonable and medically justified. The work hardening program was highly structured, goal oriented, and individualized. More importantly, the program had a defined return to work goal, which the claimant demonstrated with readiness.

Criteria/Guidelines utilized: TDI/DWC rules and regulations.

Physician Reviewers Specialty: Pain Management

Physician Reviewers Qualifications: Texas licensed M.D.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider 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 carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.

Your Right to Appeal

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 (other than a spinal surgery prospective 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.