



**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:	MDR Tracking No.: M5-06-1265-01
Buena Vista Workskills 5445 La Sierra Dr. #204 Dallas, Texas 75231	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  TX Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Documents include the DWC-60 package. Position Summary states, "The services that were provided were medically necessary."

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

Documents include the DWC-60 response. Position Summary states, "'Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above.'"

#### 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)
3-14-05 – 3-18-05	Work Hardening Program	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

#### 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.

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

28 Texas Administrative Code Sec. 133.308

**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 additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

5-10-05

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.**

NOTICE OF INDEPENDENT REVIEW DECISION

May 5, 2006

Program Administrator  
Medical Review Division  
Division of Workers' Compensation  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Claim #:  
Injured Worker:  
MDR Tracking #: M5-06-1265-01  
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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 TMF physician reviewer who is board certified in Physical Medicine & Rehab which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1981. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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 decision before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient sustained a work related injury on \_\_\_ when, while working on a pumping unit, he caught his left hand and lacerated and fractured his left index finger and left middle finger. The patient has been treated with surgical interventions, post operative hand therapy, and a work hardening program.

### Requested Service(s)

Work hardening program from 03/14/2005 through 03/18/2005

### **Decision**

It is determined that the work hardening program from 03/14/2005 through 03/18/2005 was not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

This patient was in need of left upper extremity strengthening which could have been provided by an occupational therapist. There are no other injuries noted that would require a work hardening program. His general conditioning needs could be met by the patient himself with walking, jogging, and upper extremity strengthening.

This decision by the IRO is deemed to be a DWC decision and order.

### **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.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

### **Information Submitted to TMF for Review**

**Patient Name:** \_\_\_                      **Tracking #:** M5-06-1265-01

### **Information Submitted by Requestor:**

- Letter of Medical Necessity
- Initial Behavioral Medicine Consultation
- Second functional capacity evaluation
- Work hardening daily progress notes
- Work hardening daily flow sheets
- Group psychotherapy progress notes
- Message therapy notes

**Information Submitted by Respondent:** \_\_\_\_\_ **None**