THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-03-3423.M5

MDR Tracking Number: M5-03-0267-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

Date of service 9/28/01 was withdrawn by the requestor, therefore will not be addressed further in this Finding and Decision.

The Medical Review Division has reviewed the IRO decision and determined, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The initial office visits with therapies, mobilization and myofascial release were found to be medically necessary. The therapeutic exercise and group therapies procedures were not medically necessary for treatment. The respondent raised no other reasons for denying reimbursement for these charges, office visits and therapies, mobilization and myofascial release.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 1/28/02 through 3/13/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 29th day of April 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

December 16, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0267-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on ___ external review panel. ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 46 year-old female who sustained a work related injury on ___. The patient states that while putting away some groceries, she tripped over a box and landed directly on her buttocks in a sitting position. She states she had immediate pain. The patient's diagnoses include displacement of lumbar intervertebral disc without myelopathy, lumbar facet syndrome, and myofascial pain syndrome. The patient has had an MRI. She has been treated with medications, physical therapy, and epidural steroid injections.

Requested Services

Physical Therapy Sessions, muscle testing, office visits, and required reports on 1/28/02 through 3/13/02.

Decision

The Carrier's denial of coverage for these services is partially overturned.

Rationale/Basis for Decision

___ chiropractor reviewer noted that this patient sustained a work related injury on ___. ___ chiropractor reviewer explained that there was no real improvement in the patient's condition after the first 18 visits, and that the patient began home therapy after these visits. ___ chiropractor reviewer also explained that the patient then had an epidural injection that did help with her condition and that a second round of chiropractor care was initiated after the injection. ___ chiropractor reviewer also indicated that this second round of treatment was acceptable under AHCPR and Mercy Guidelines. ___ chiropractor reviewer further explained that the extensive therapy sessions did not provide any additional relief and could have been done at home. ___ chiropractor reviewer concluded that because the patient did not benefit from all visits from 1/28/02 through 3/13/02, only the first 11 visits were medically necessary. Therefore, ___ chiropractor consultant concluded that the initial eleven visits of mobilization and myofascial release were medically necessary to treat this patient's condition, but that the remainder of these services including the therapeutic exercise and group therapy procedures, were not medically necessary for treatment of her condition.

Sincerely,