

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.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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 office visits and physical therapy treatments were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits and physical therapy treatment charges.

This Finding and Decision is hereby issued this 2nd day of January 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

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 1/18/02 through 7/12/02 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 2nd day of January 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/cl

December 4, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-03-0412-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered 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 Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

While working for ___, ___ injured her low back while lifting a 50 lb. Box. An FCE was performed on 9/18/00 and a therapeutic exercise was recommended. An MRI dated 9/26/00 revealed a 3.5 mm left sided disc protrusion. On 6/4/01, ___ performed surgery, a discectomy and microhemilaminectomy on the left at L3-L4.

On 6/20/01 ___ began postoperative rehabilitation with ___ which continued through 8/30/01. The patient began work hardening 10/12/01 and developed recurrent left leg pain.

A repeat MRI was requested by ___ on 11/28/01 to rule out recurrent disc herniation. The MRI was performed on 12/9/01 and revealed a large centrally located recurrent disc protrusion measuring 14mm at L3-4 level.

On 2/4/02, a left partial hemilaminectomy and discectomy was performed a second time. ___ began post-surgical rehabilitation on referral of the orthopedic surgeon with ___.

On 5/21/02, ___ saw ___, who determined her to be at statutory MMI.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits and physical therapy rendered from 1/18/02 through 7/12/02 for ___.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The documentation provided clearly supports an exacerbation and worsening of the work-related L3-4 disc herniation. This reoccurrence resulted in a repeat surgery and necessary chiropractic care. The care rendered by ___ falls within the parameters set forth in the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters. ___ care was found to enhance ___ ability to return to her job duties as a productive employee.

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

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,