MDR Tracking Number: M5-03-0573-01

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.

The Medical Review Division has reviewed the IRO decision and determined that the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare; 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 office visits w/manipulations and physical therapy sessions from 3-11-02 through 3-22-02 were found to be medically necessary. The office visits w/manipulations, physical therapy, FCE, psych diagnostic interview, and psych status report from 5-01-02 through 6-17-02 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these services charges.

The above Findings and Decision are hereby issued this 12th day of May 2003.

Dee Z. Torres
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 3-11-02 through 6-17-02 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 12th day of May 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dzt

January 14, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0573-01

___ 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 60 year-old male who sustained a work related injury on ___. The patient reports no specific traumatic injury. The patient's diagnosis was lower back strain. The patient had an EMG/NCV on 10/11/01 that showed lumbar radiculopathy at S1, an MRI on 11/13/01 that was unremarkable for any acute structural pathology, and an FCE on 12/11/01 at which time a work-conditioning program was recommended.

Requested Services

Therapeutic procedure, office visit with manipulations, myofascial release, traction, ultrasound, functional capacity evaluation, psych status report, psych diagnostic interview from 3/11/02 through 6/17/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

___ chiropractor reviewer noted that the patient sustained a work related injury to his lower back on ___. ___ chiropractor reviewer explained that the patient did require treatment for his work related injury. However, ___ chiropractor reviewer also explained that the patient's injury did not require a full 14 weeks of treatment. ___ chiropractor reviewer further explained that 7 weeks of

treatment was medically necessary to treat this patient's condition. Therefore, ___ chiropractor consultant concluded that therapeutic procedure, office visit with manipulations, myofascial release, traction, ultrasound, functional capacity evaluation, psych status report, psych diagnostic interview from 3/11/02 through 4/29/02 were medically necessary to treat this patients condition. However, ___ chiropractor consultant concluded that treatment rendered from 4/30/02 through 6/17/02 was not medically necessary to treat this patient's condition.

Sincerely,

___