MDR Tracking Number: M5-03-0667-01

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 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 $650.00** 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 therapeutic activities, therapeutic procedure, office visits and range of motion testing were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these therapeutic activities, therapeutic procedure, office visits and range of motion testing charges.

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 6/5/02 through 8/22/02 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 27th day of February 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

January 24, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0667-01

___ 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 55 year-old female who sustained a work related injury on ___. The diagnoses for this patient were cervical herniated disc, and cervical sprain. The patient has been treated with physical therapy, oral medications, and work hardening. The patient has had an MRI and cervical myelogram.

Requested Services

Therapeutic activities, therapeutic procedure, office visit, range of motion testing from 6/5/02 through 8/22/02.

Decision

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

Rationale/Basis for Decision

___ chiropractor reviewer concluded after reviewing the medical records provided, the therapeutic activities, therapeutic procedure, office visit, and range of motion testing from 6/5/02 through 8/22/02 were medically necessary to treat this patient's condition. (Mercy Guidelines). ___ chiropractor reviewer indicated that the patient had sustained a work related injury on ___. ___ chiropractor reviewer noted that the patient had undergone a cervical myelogram and MRI.

___ chiropractor reviewer explained that the patient's diagnoses were cervical herniated disc and cervical sprain. Therefore, ___ chiropractor consultant concluded that the therapeutic activities, therapeutic procedure, office visits, and range of motion testing from 6/5/02 through 8/22/02 were medically necessary to treat this patient's condition.

Sincerely,