

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 chiropractic outpatient treatment/services rendered from 3/12/02 through 4/23/02 were found to be medically necessary. The chiropractic outpatient treatment/services rendered after 4/23/02 (through 6/27/02) were found to be not medically necessary. The respondent raised no other reasons for denying reimbursement for the chiropractic outpatient treatment/service charges.

This Finding and Decision is hereby issued this 2<sup>nd</sup> day of June 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 13/12/02 through 6/27/02 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 2<sup>nd</sup> day of June 2003.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/cl

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** April 9, 2003

**Requester/ Respondent Address :** Rosalinda Lopez  
TWCC  
4000 South IH-35, MS-48  
Austin, Texas 78704-7491

**RE: MDR Tracking #:** M5-03-0700-01  
**IRO Certificate #:** 5242

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 proposed 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 Chiropractic physician reviewer. The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

### **Clinical History**

On 1/22/02, the above named claimant underwent a triple surgical procedure including right ulnar nerve release, right cubital tunnel release, and right radial tunnel release. Six weeks following this procedure on or about 3/12/02 the injured worker began a physical therapy program under the care of the \_\_\_.

### **Requested Service(s)**

The medical necessity of outpatient services rendered 3/12/02 through 6/27/02.

### **Decision**

I am in partial agreement with the insurance carrier on the medical necessity of the services rendered from 3/12/02 through 6/27/02. I feel that services from 3/12/02 through 4/23/02 were medically necessary.

### **Rationale/Basis for Decision**

Post operative therapy is reasonable and necessary for the duration of six weeks when supported by adequate documentation. Provided for my review are several comparative muscle test/range of motion evaluations. They have chronicled the regular improvements in this patient's condition. However, there is inadequate documentation to justify the therapy sessions that are outside this time frame of six weeks, 4/23/02. Through this six week window the injured worker received 16 sessions of chiropractic therapy.

Although the documentation is provided in the form of additional comparative muscle test/range of motion studies and functional capacity evaluations, the data does not amount to significant improvements that would warrant the current level of utilization past 4/23/02.

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

<p>In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 9th day of April 2003.</p>
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