MDR Tracking Number: M5-03-0904-01

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 $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 disputed electrical stimulation, myofascial release, MP office visits and physical therapy were found to be medically necessary. The respondent raised no other reasons for denying reimbursement.

This Finding and Decision is hereby issued this 17th day of April 2003.

Noel L. Beavers
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 date of service 10/11/01 through 4/5/02.

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 17th day of April 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/nlb

April 11, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0904-01

___ 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 the ___ external review panel. The ___ 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, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 32 year-old female who sustained a work related injury on ___. The patient reported that while working as a bus driver she ran into the rear end of another vehicle. The diagnoses for this patient included cervical sprain/strain. The patient was initially treated with physical therapy for one month without relief. She then transferred her care to another physician where she was treated with chiropractic care including electrical stimulation, myofascial release/soft, and physical therapy.

Requested Services

Electrical Stimulation, myofascial release/soft, office visits and physical therapy from 10/11/01 through 4/5/02.

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

The ___ chiropractor reviewer noted that the patient sustained a work related injury on ___. The ___ chiropractor reviewer also noted that the patient was treated with electrical stimulation, myofascial realease/soft and physical therapy from 10/11/01 through 4/5/02. The ___

chiropractor reviewer explained that the patient responded reasonably well to the treatment rendered. The ___ chiropractor reviewer also explained that the treatment rendered from 10/11/01 through 4/5/02 was reasonable and medically necessary. Therefore, the ___ chiropractor consultant concluded that the office visits, electrical stimulation, myofascial release/soft and physical therapy from 10/11/01 through 4/5/02 were medically necessary to treat this patient's condition.

Sincerely,

___