MDR Tracking Number: M5-03-0925-01

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 **or January 1, 2003** 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(r)(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 treatments/services rendered 3-5-02 to 4-25-02 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these charges.

The above Findings and Decision are hereby issued this 21st 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 3-5-02 through 4-25-02 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 21st day of May 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

DZT/dzt

February 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0925-01

___ 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 26 year-old female who sustained a work related injury to her low back on ___. The patient reported that while at work she sustained an injury to her back when she was moving boxes and folding tables. The patient reported that she was evaluated by the company doctor and diagnosed with lumbar sprain/strain and treated with physical therapy. The patient had an MRI of the lumbar spine. She has been treated with biofreeze application, TENS unit, lumbar facet joint injections at L2-3 and L5-S1, chiropractic manipulations, and oral pain medications.

Requested Services

Electrical stimulation, therapeutic exercises, myofascial release/soft, special reports as Insurance, MP office outpatient visits, durable medical equipment, PT one area, therapeutic procedures group, supplies and TENS from 3/5/02 through 4/25/02.

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 to her low back on ___. The ___ chiropractor reviewer also noted that the patient was treated with physical

therapy, biofreeze application, TENS unit, lumbar facet joint injections at L2-3 and L5-S1, chiropractic manipulations, and oral pain medications. The ___ chiropractor reviewer explained that the treatment from 3/5/02 through 4/25/02 was reasonable and medically necessary. Therefore, the ___ chiropractor consultant concluded that the electrical stimulation, therapeutic exercises, myofascial release/soft, special reports as Insurance, MP office outpatient visits, durable medical equipment, PT on area, therapeutic procedures group, supplies and TENS from 3/5/02 through 4/25/02 were medically necessary to treat this patient's condition.

Sincerely,

___