MDR Tracking Number: M5-03-0927-01

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 office visits, physical therapy, reports, FCE, and neuromuscular stimulator rental were found to be medically necessary from 2/6/02 through 9/17/02. The analysis code (CPT code 99090) was withdrawn from the dispute for dates of service 1/15/02, 2/11/02, 2/14/02, 4/8/02, 9/17/02 and 9/24/02. The respondent raised no other reasons for denying reimbursement for these office visits, physical therapy, reports, FCE, and neuromuscular stimulator rental charges.

This Finding and Decision is hereby issued this 13th day of, March 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 1/15/02 through 9/17/02 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 13th day of March 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/cl

March 5, 2003

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR #: M5.03.0927.01
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Chiropractic Medicine.

Clinical History:
This male claimant was injured on his job on ___, after which chiropractic care and passive therapy was begun. As he was able to tolerate, the patient was progressed into an active rehabilitation program. In addition, he was sent for an orthopedic consultation and was given a caudal epidural injection.

The patient continued active rehabilitation exercises and procedures until such time as a work hardening program begun on 05/13/02.

Disputed Services:
Office visits, physical therapy, FCE, neuromuscular stimulation rental from 02/16/02 thru 09/17/02.

Decision:
The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the office visits, therapies, testing and equipment rental as stated above was medically necessary in this case.

Rationale for Decision:
The FCE was absolutely necessary to monitor the patient's progress throughout the program. The office visits were necessary to measure and document the patient's response to treatment, as well as for the oversight and direction of proper treatment procedures. The neuromuscular stimulation unit was necessary to assist the patient with pain control, to increase range of motion, and to decrease muscle spasm. The monitoring of this unit's usage was necessary so the treating doctor could make the necessary modifications as needed.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,