

MDR Tracking Number: M5-03-1120-01

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 office visits, supplies and physical therapy were found to be medically necessary. The respondent raised no other reasons for denying reimbursement.

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 1/23/02 through 10/1/02.

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 2nd day of April 2003.

Noel L. Beavers  
Medical Dispute Resolution Officer  
Medical Review Division

NLB/nlb

March 26, 2003

#### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-03-1120-01**

\_\_\_ 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 31 year-old male who sustained a work related injury to his lower back on \_\_\_. The patient has also had a previous low back injury on \_\_\_. The patient reported that while at work on \_\_\_, he was doing work on serpentine belts when he experienced lower back pain. The patient reported that later that day he developed right hip, thigh and shoulder/neck pain. The patient was evaluated and had X-Rays taken of his low back and was sent to therapy. The patient reported that the one session of therapy did not help. The patient was then evaluated on 8/10/00 and was diagnosed with lumbar sprain/strain and myofascial pain syndrome. The patient was referred for pain management and a neurologist evaluation. The patient was treated with active and passive therapy, home program of exercises, and chiropractic care. The patient has had an MRI.

### Requested Services

Office visits, supply analgesic balm, and physical therapy from 1/23/02 through 10/1/02.

### 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 indicated that the patient appears to have some chronic residual pain and strain that seems to be aggravated by his work. The \_\_\_ chiropractor reviewer noted that the patient's care is currently on an as needed basis. The \_\_\_ chiropractor reviewer also noted that the patient has attempted to manage his condition on his own until he finds he needs help. The \_\_\_ chiropractor reviewer further noted that the patient does experience relief from treatment for periods of a few days up to a few weeks. The \_\_\_ chiropractor reviewer indicated that the patient is working full time without restrictions and most likely has some mild permanency to his condition. The \_\_\_ chiropractor reviewer explained that the patient is entitled to periodic care for acute exacerbations for the low back, neck and shoulder. The \_\_\_

chiropractor reviewer noted that his exacerbations have been documented as to being related to his working and heavy lifting. Therefore, the \_\_\_ chiropractor consultant has concluded that the office visits, supply analgesic balm, and physical therapy from 1/23/02 through 10/1/02 were medically necessary to treat this patient's condition.

Sincerely,

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