MDT Tracking Number: M5-03-1186-01

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 requestor submitted a medical dispute resolution request on 1/14/03 and was received in the Medical Dispute Resolution on 1/14/03. The disputed date of service 1/11/02 is not within the one year jurisdiction in accordance with Rule 133.308(e)(1) and will be excluded from this Finding and Decision.

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** 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 with manipulations, myofascial release, physical medicine treatments and neuromuscular stimulator were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the office visits with manipulations, myofascial release, physical medicine treatments and neuromuscular stimulator charges.

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 1/14/02 through 3/6/02 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 10th day of April 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

April 4, 2003

Re: IRO Case # M5-03-1186

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The ___ reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment was not medically necessary. Therefore, ___ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

History
The patient was injured in ___, reportedly due to repetitive use of the computer. The injured body parts were stated to be bilateral wrists. The patient sought chiropractic care on 1/2/02; her main complaints involved the neck and upper back.

Requested Service(s)Office visits with manipulations, myofascial release, physical medicine treatments, neuromuscular stimulator 1/14/02, 3/6/02

Decision
I disagree with the carrier's decision to deny the requested treatment as not medically necessary.

Rationale
The patient's symptoms were of mild myofascial findings and trigger points in the neck and upper back. The treatments given were medically necessary to help decrease the patient's symptoms. According to chiropractic physiological and rehabilitation guidelines, the treatments rendered were within the standards of chiropractic practice.

The documentation provided for this review does not give any indication that the patient's problems in ___ were a continuation of her previous symptoms. The medical records presented for this review indicate that the patient only had bilateral wrist symptoms in ___. However, when the patient was seen in ___, her main complaints related to her neck and upper back. This may be a new injury.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

_____