MDR Tracking Number: M5-03-1217-01

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 x-rays of the cervical, lumbar, thoracic spine and shoulder were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for x-rays of the cervical, lumbar, thoracic spine and shoulder 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 date of service 7/29/02.

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 9th day May 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

April 24, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-1217-01
IRO Certificate #: IRO 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating 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 the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ___ when she was involved in a motor vehicle accident and was thrown to the right while striking her head on the dashboard and headrest. Examination revealed complaints of headaches, neck pain, low back pain, bilateral shoulder pain, and left thigh pain. The patient underwent radiographs of the cervical spine, lumbar spine, and right/left shoulder.

Requested Service(s)

X-rays of the cervical, lumbar, thoracic spine and shoulder

Decision

It is determined that the x-rays of the cervical, lumbar, thoracic spine and shoulder were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient was involved in a dual impact motor vehicle accident with impacts reported to the front and rear passenger portions of her automobile. Each impact has the possibility of creating separate osseous injuries. Osseous and other possible pathology that could complicate the initiation of mechanical therapy must be ruled in/out. Prior to initiation of mechanical based therapies, accurate reading and interpretation of the radiographic data is vital to the management of this patient's care. Therefore, the x-rays of the cervical, lumbar, thoracic spine and shoulder were medically necessary.

Sincerely,