MDR Tracking Number: M5-03-1221-01

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, 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(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 physical therapy and muscle testing 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 1/16/02 through 4/5/02.

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 May 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division
NLB/nlb

April 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1221-01

___ 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 38 year-old female who sustained a work related injury on ___. The patient reported that while at work she was restraining a child when she was kicked in her back. The patient was initially treated with physical therapy for approximately three months followed by trigger point injections. The diagnoses for this patient included herniated disc from L2-L3 and L5-S1, thoracic sprain of ligamentous structures and sprain of the myscylotendinous structures of the same area. The patient then underwent a lumbar discectomy and fusuion on 3/26/01. The patient was then referred for post surgery rehabilitation and therapy.

Requested Services

Physical therapy and muscle testing from 1/16/02 through 4/5/02.

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 on ___. The ___ chiropractor reviewer also noted that the patient underwent lumbar discectomy and fusion on 3/26/01. The ___ chiropractor reviewer indicated that this patient was referred to physical therapy from 1/16/02 through 4/5/02. The ___ chiropractor reviewer explained that the physical therapy and muscle testing from 1/16/02 through 4/5/02 was appropriate and medically necessary for this patient. Therefore, the ___ chiropractor consultant concluded that the physical therapy and muscle testing from 1/16/02 through 4/5/02 was medically necessary for treatment of this patient's condition.

Sincerely,