MDR Tracking Number: M5-03-1276-01

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 total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare; therefore, the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 visit on 1-29-02 was found to be medically necessary. The physical therapy and DME on 4-19-02 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these services 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 1-29-02 through 4-19-02 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 9th day of May 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

April 23, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1276-01

___ 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 44 year-old female who sustained a work related injury on ___. The patient reported that she worked as a service representative for 20 years before she started experiencing pain in the right shoulder, right arm and neck. The patient has had an MRI and plain films of the shoulder and cervical neck area. The dianoses for this patient included subacromial bursitis, pericervical/scapular myofascial pain, carpal tunnel syndrome and ulnar neuritis. The patient has had a neurology and orthopaedic evaluation. The patient has been treated with physcical therapy, occupational therapy and trigger point injections.

Requested Services

Office visit, physical therapy and durable medical equipment from 1/29/02 through 4/19/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially 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 was evaluated on 1/29/02. The ___ chiropractor reviewer further explained that the patient was declared to be at maximum medical improvement on 1/29/02. The ___ chiropractor reviewer also explained that the evaluation of 1/29/02 was medically necessary. However, the ___ chiropractor reviewer further explained that the patient was declared at maximum medical improvement on 1/29/02 and that no further treatment was medically necessary. Therefore, the ___ chiropractor consultant concluded that the office visit, treatment, and supplies on 1/29/02 were medically necessary to treat this patient's condition. However, the ___ chiropractor consultant concluded that the office visits, physical therapy and durable medical equipment from 1/30/02 through 4/19/02 were not medically necessary to treat this patient's condition.

Sincerely,