MDR Tracking Number: M5-03-1281-01

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 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 3/19/02 through 3/29/02.

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 4th day of April 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 1, 2003

Requester/ Respondent Address : Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-03-1281-01
IRO Certificate #: 5242

___ 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 proposed 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 Chiropractic physician reviewer. The Chiropractic physician reviewer 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

According to the documentation supplied, claimant sustained an injury to his low back on ___ while trying to lift a table. He was treated by D.C. for 4 weeks and was returned to full duty. The claimant reported that he continued to have a low-grade pain, but in late 02/2002 it returned with increased pain. The claimant reported on 03/02/2002, his pain became extreme and he returned to care on 03/04/2002. The letter from the doctor stated that the claimant had a MRI performed on 03/29/2002, which revealed a 5 mm disc protrusion at L4-5 and a 3 mm at L3-4. The claimant received active and passive therapies and was released to work without restriction at the end of treatment. The letter also stated there was a referral to an orthopedic specialist on 04/19/2002. The documentation ends here.

Requested Service(s)

The medical necessity of the outpatient services rendered between 03/19/2002 and 03/29/2002.

Decision

I disagree with the insurance company and agree with the treating doctor that the services rendered between 03/19/2002 and 03/29/2002 were medically necessary.

Rationale/Basis for Decision

With the limited documentation submitted, it appears that the claimant had an exacerbation of his ___ on-the-job injury. The claimant was treated for a brief period and referred to the proper specialist. This appears to be reasonable and within normal treatment protocols for this type of injury. The treating doctor was able to treat the claimant and within a short timeframe, have him

back to work without any job restrictions. Short-term passive and active care is an appropriate treatment for an acute exacerbation. This treatment is clearly within TWCC treatment guidelines.

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 1st day of April 2003.