

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 chiropractic treatments and services 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 10/29/01 through 11/14/01.

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 13<sup>th</sup> day of May 2003.

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

**NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** April 28, 2003

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

**RE: MDR Tracking #:** M5-03-1447-01  
**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 Chiropractor physician reviewer. The chiropractor 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 received, it appears that the claimant strained his left wrist on \_\_\_ while working. He was originally seen on 10/17/2001 at \_\_\_ and was diagnosed with a strain. Plain film x-rays revealed no abnormalities. The claimant was given a splint and was sent back to work. The claimant then went to see the chiropractor on 10/19/2001 for evaluation. The chiropractor began chiropractic therapy on the claimant. The claimant was also removed from work. The claimant received approximately 15 sessions of therapy in a 4-week period. The claimant was also seen by the doctor who reported the claimant still had swelling. The doctor injected the claimant's wrist with Marcaine, Lidocaine and Celestone and recommended more physical therapy. The claimant reported on 11/12/2001 that his pain had improved 50%. According to a letter from \_\_\_ after the claimant returned to work he quit coming in for appointments. The documentation ends here.

### **Requested Service(s)**

Were the chiropractic treatments and services rendered from 10-29-2001 until 11-14-2001 medically necessary?

### **Decision**

I disagree with the insurance company and agree with the treating doctor that the services provided between 10-29-2001 – 11-14-2001 were medically necessary.

### **Rationale/Basis for Decision**

The claimant apparently suffered a strain at work according to all sources submitting documentation. This claimant was seen for a period of one month, which is considered within a normal timeframe for the treatment of a strain. According to the doctor's notes, the claimant continued to have objective findings on 10-26-2001 and recommended continued therapy. The claimant was only seen for approximately 3 weeks following this recommendation. The claimant returned to work and has not returned for care. The documentation supports the treatment rendered.

<p>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 28<sup>th</sup> day of April 2003.</p>
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