MDR Tracking Number: M5-03-1478-01

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 office visits, physical therapy session and spray and stretch treatment/services were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these office visits, physical therapy session and spray and stretch treatment/service 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 8/27/02 through 10/15/02 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 24th day of, June 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division
CRL/crl

June 17, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M5-03-1478-01

___ 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 47 year-old female who sustained a work related injury on ___. The patient reported that while at work she was attempting to restrain a student when she experienced a strange sensation in her upper-back. The patient reported that after the incident, she began to experience pain in her thoracic and lumbar spine and her left shoulder. The patient has undergone X-Rays of the cervical spine 11/28/00, MRI of the cervical spine 1/11/01, MRI of the right shoulder 2/15/01, and electrodiagnostic studies of the upper extremities on 2/22/01 and 4/3/01.The diagnoses for this patient included cervical spondylosis, brachial neuritis or radiculitits, disorders of bursae and tendons in the shoulder region, and impingement of shoulder region. The patient has been treated with joint mobilization; massage therapy, spray and stretch treatment and electrical stimulation

Requested Services
Office visits, physical therapy session and spray and stretch on 8/27/02 through 10/15/02

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 this case concerns 47 year-old female who sustained a work related injury to her back and left shoulder. The ___ chiropractor reviewer also noted that the diagnoses for this patient included cervical spondylosis, brachial neuritis, and disorders of bursae and tendons in the shoulder region and impingement of shoulder region. The ___ chiropractor reviewer further noted that the treatment for this patient's condition has included joint mobilization; massage therapy, spray and stretch treatment and electrical stimulation. The ___ chiropractor reviewer explained that after a review of the medical records, the treatment from 8/27/02 through 10/15/02 was medically necessary. Therefore, the ___ chiropractor consultant has concluded that the office visits, physical therapy session and spray and stretch on 8/27/02 through 10/15/02 were medically necessary to treat this patient's condition.

Sincerely,