

MDR Tracking Number: M5-03-1628-01

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 physical therapy and chiropractic treatment were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for physical therapy and chiropractic treatment charges.

This Finding and Decision is hereby issued this 9th day of May 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

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 2/27/02 through 7/3/02 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 May 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/mqo

April 29, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

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___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This patient was injured on his job and sustained injuries to the neck, shoulders and into the wrists. It was determined that some of the pain in the wrists may have been related to the cervical spine injuries, and MRI was performed at the request of the treating doctor on this case. Cervical spine MRI revealed a bulge at C3/4, a herniation at C4/5 measuring 2.5 mm and a large 4 mm herniation at C6/7. Right shoulder MRI did indicate a soft tissue type of injury, but it did not seem to involve the rotator cuff. A wrist MRI on the right did apparently indicate an internal derangement possible and suggested a CT scan to rule out a TFC tear. According to the records, the patient was treated for a total of 14 visits with mostly active care by the requestor.

DISPUTED SERVICES

The carrier has denied the medical necessity of physical therapy and chiropractic treatment from February 27, 2002 through July 3, 2002

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The treatment in this case was rendered and well documented by the treating doctor. The care rendered did show progress from date to date and the progress was within the guidelines of the TCA Guides to Quality Assurance. The patient was post-surgical for some of the treatment and the treatment rendered did improve the patient's functional ability from the records enclosed. I find that the treatment was reasonable and necessary for this patient to return to work.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,