MDR Tracking Number: M5-03-1947-01

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 chiropractic treatments were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these chiropractic treatment charges.

This Finding and Decision is hereby issued this 27th day of May 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

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 7/15/02 through 12/2/02 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 27th day of May 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/cl

May 23, 2003

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

MDR Tracking #: M5-03-1947-01
IRO #: 5251

___ 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.

The independent review was performed by a matched peer with the treating doctor. 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

___ was sustained a work-related injury on ___ and presented to ___ office on 6/7/02. He was in a severely antalgic position with forward lean and gait disturbance. The patient was referred to an Orthopedists, ___. and to ___ for epidural steroid injections. The Designated Doctor found him to be at MMI as of 1/29/03 with a 10% impairment rating.

DISPUTED SERVICES

Under dispute is the medical necessity of chiropractic treatments rendered from 7/15/02 through 12/2/02 for this injured worker.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

___ was injured on ___ and documentation shows a severely antalgic posture with forward lean and antalgic gait. He was treated conservatively and the appropriate referrals were made. An MRI showed "L5/S1: Moderately severe impingement on the left lower neuroforamen due to annular bulging; & L4/5:

Annular tear and shallow left posterolateral disc protrusion with mild effacement of fat in the lateral recess." The carrier has denied treatment, as per the EOB, for code U, "unnecessary treatment without peer review," and with rationale RG, "the treatment/service provided exceeds medically accepted utilization review criteria and/or reimbursement guidelines established for severity of injury, intensity of service and appropriateness of care." The objective findings diagnoses and treatments were appropriately documented and the patient did progress with this care. The reviewer finds that medical necessity has been established for the disputed treatment.

___ 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,